

AMENDED IN SENATE JUNE 23, 2003

CALIFORNIA LEGISLATURE—2003–04 REGULAR SESSION

ASSEMBLY BILL

No. 1762

Introduced by Committee on Budget (Oropeza (Chair), Bermudez, Chan, Chu, Diaz, Dutra, Dymally, Goldberg, Hancock, Jackson, Liu, Montanez, Nakano, Pavley, Reyes, Simitian, and Wolk)

March 11, 2003

~~An act relating to the Budget Act of 2003.~~ *An act to amend Sections 6254 and 16531.1 of, and to repeal Section 13967 of, the Government Code, to amend Sections 1266, 104465, 104898.5, 120955, 124555, 124710, and 127280.1 of, to amend and repeal Section 1316.5 of, to add Sections 104181.6, 104466, 123853, and 125191 to, to add Article 7.5 (commencing with Section 1324) to Chapter 2 of Division 2 of, and to add Chapter 16 (commencing with Section 121345) to Part 4 of Division 105 of, the Health and Safety Code, to amend Sections 12693.43, 12693.70, 12693.73, 12693.91, 12693.98, 12695.04, 12695.06, 12695.08, 12696.7, 12697, 12698.05, 12698.30, 12699.50, 12699.51, 12699.52, 12699.53, 12699.54, 12699.56, 12699.58, 12699.60, 12699.61, and 12699.62 of, to amend the heading of Part 6.4 (commencing with Section 12699.50) of Division 2 of, to add Section 12693.765 to, and to repeal Sections 12693.99 and 12698.10 of, the Insurance Code, to amend Section 1026.2 of the Penal Code, to amend Sections 4094.2, 4433, 4512, 4631.5, 4640.6, 4643, 4685.5, 4781.5, 5775, 14011.7, 14019.3, 14105.37, 14124.79, 14154, and 16809 of, to amend and repeal Sections 14005.81 and 14110.65 of, to add Sections 4620.2, 4648.4, 4681.5, 4691.6, 14044, 14087.101, 14087.103, 14087.105, 14105.21, 14105.22, 14105.395, 14105.48, 14105.86, 14124.795, 14132.27, 14159, and 14684.1 to, and to add Article 5.5*

(commencing with Section 14464.5) to Chapter 8 of Part 3 of Division 9 of, the Welfare and Institutions Code, and to repeal Section 13 of Chapter 9 of the Statutes of the First Extraordinary Session of 2003, relating to health, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 1762, as amended, Committee on Budget. ~~Budget Act of 2003~~
Health.

Existing law establishes a Restitution Fund to assist residents of the state in obtaining compensation for certain injuries suffered by victims of crime and derivative victims, as defined.

Existing law requires that the Governor's Budget specify the estimated amount in the Restitution Fund that is in excess of the amount needed to pay claims against the Restitution Fund and administer the program. It authorizes use of moneys appropriated in the annual Budget Act in accordance with this provision to be used to fund programs and activities operated by the State Department of Mental Health that address the problem of unequal protection for, and unequal services to, crime victims with disabilities, as specified.

This bill would repeal this authorization and the related Governor's Budget requirements.

Existing law creates the continuously appropriated Medical Providers Interim Payment Fund, for the purposes of paying Medi-Cal providers, providers of drug-treatment services for persons infected with HIV, and providers of services for the developmentally disabled, during any portion of a fiscal year, prior to September 1 of that year, in which a budget has not yet been enacted, and would appropriate, for each fiscal year in which these payments were necessary, up to \$1,000,000,000 from the General Fund, in the form of loans, and \$1,000,000,000 from the Federal Trust Fund to the Medical Providers Interim Payment Fund.

This bill would revise the application of that provision to also permit payments from the fund to the providers described above during the period in which Medi-Cal has a deficiency, thus constituting an appropriation.

Existing law provides for the licensing and regulation of health facilities by the State Department of Health Services. A violation of those provisions is a misdemeanor.

Existing law sets forth the licensing and renewal fee to be charged certain health facilities, as defined. The annual fee is waived for any health facility conducted, maintained, or operated by this state or any state department, authority, bureau, commission, or officer, by the Regents of the University of California, or by a local hospital district, city, county, or city and county. Existing law requires that the fees be adjusted annually, as directed by the Legislature in the annual Budget Act. Existing law requires that the methodology and calculations used to determine the fee amounts result in fee levels in an amount sufficient to provide revenues equal to the sum of various expenditures.

This bill would revise these licensing and renewal fee provisions. The bill would require, if the Budget Act provides for expenditures that differ by 5% from the Governor's proposed budget, the Department of Finance to adjust the fees to reflect that difference and to instruct the State Department of Health Services to publish those fees as prescribed. By increasing health facility requirements, this bill would change the definition of a crime, and would result in a state-mandated local program.

This bill would require that, as a condition of participation in the Medi-Cal program, there be imposed a quality assurance fee on certain intermediate care facilities. The bill would require that the fee shall be placed in the General Fund and allocated to intermediate care facilities to support their quality improvement efforts, and distributed to each facility based on the number of Medi-Cal patients at the eligible facility. The bill would require the department to seek federal approval for the implementation of the fee. By increasing health facility requirements, this bill would change the definition of a crime, and would result in a state-mandated local program.

Existing law, until January 1, 2007, requires each health facility owned and operated by the state offering care or services within the scope of practice of a psychologist to establish rules and medical staff bylaws that include provisions for medical staff membership and clinical privileges for clinical psychologists within the scope of their licensure as psychologists, subject to any rules and medical staff bylaws governing medical staff membership or privileges the facility shall establish. Existing law requires, among other things, that the rules and medical staff bylaws of the health facility not discriminate on the basis of whether the staff member holds an M.D., D.O., D.D.S., D.P.M., or doctoral degree in psychology, within the scope of the member's respective licensure.



Existing law further provides that on January 1, 2007, provisions that relate to staff privileges for clinical psychologists, that do not contain the above requirements, shall become operative.

This bill would delete the January 1, 2007, repeal date for the above requirements, thereby extending the operation of these provisions indefinitely. It would also repeal the new provisions that would take effect on January 1, 2007. Because this bill would extend criminal penalties for violation of these provisions past the January 1, 2007, repeal date, this bill would create a state-mandated local program.

Existing law provides that an appropriation is available for encumbrance during the period specified therein, or, if not otherwise limited by law, for 3 years after the date upon which it first became available for encumbrance. Subdivision (a) of Section 2.00 of the Budget Act of 2002 provides that appropriations in the act, unless otherwise provided, are appropriated for the use and support of the state for the 2002–03 fiscal year.

Existing law provides for a Cancer Research Program administered by the State Department of Health Services. Existing law prohibits the department, in awarding grants under this program, from encumbering money allocated in any fiscal year other than the fiscal year in which the appropriation was made.

This bill would provide that, notwithstanding any other provision of law, commencing with the appropriation for the 2002–03 fiscal year, and for each fiscal year thereafter, the amount appropriated to the department for the Cancer Research Program is available for that program, for encumbrance for one fiscal year beyond the year of appropriation, and for expenditure for 3 fiscal years beyond the year of encumbrance, thereby making an appropriation.

Existing law provides for a tobacco use prevention program under which grants are awarded and administered by the State Department of Health Services and the State Department of Education for projects directed at the prevention of tobacco-related diseases and tobacco use.

Existing law requires the State Department of Health Services to annually set aside a certain amount appropriated for the competitive grants programs established under these provisions to support designated media campaign efforts.

This bill, instead, would authorize the department to make that annual set-aside. The bill would also provide that, commencing with the appropriation for the 2002–03 fiscal year, and for each fiscal year thereafter, any amount appropriated to the department to implement



designated tobacco use programs shall be available for encumbrance and expenditure for 3 fiscal years beyond the date of the appropriation, thereby making an appropriation.

Under existing law, states' attorneys general and various tobacco product manufacturers have entered into a Master Settlement Agreement, in settlement of various lawsuits, that provides for the allocation of money to the states and certain territories. The state has entered into a memorandum of understanding providing for the allocation of the state's share of moneys to be received under the Master Settlement Agreement among the state and counties and certain cities in the state.

Existing law establishes the Tobacco Settlement Fund in the State Treasury and requires that designated amounts of the state's share of funds received under the Master Settlement Agreement be deposited in the fund. Existing law authorizes an annual transfer from the General Fund to the Tobacco Settlement Fund of not to exceed \$250,000,000, out of funds not otherwise appropriated, as a loan to cover appropriations from the fund when moneys from the agreement have not been received by the state.

This bill would decrease the maximum amount that may be transferred and loaned under this provision from \$250,000,000 to \$100,000,000.

Existing law provides, to the extent that state and federal funds are appropriated in the annual Budget Act, for the establishment and administration of a program to provide drug treatments to persons infected with human immunodeficiency virus (HIV), the etiologic agent of acquired immune deficiency syndrome (AIDS).

This bill would provide that if the Director of Health Services makes a formal determination that, in any fiscal year, funds appropriated for the program will be insufficient to provide all of those drug treatments to existing eligible persons for the fiscal year and that a suspension of the implementation of the program is necessary, the director may suspend eligibility determinations and enrollment for the period of time necessary to meet the needs of existing eligible persons in the program.

This bill would also authorize the Director of the Office of AIDS to provide funding for the coverage of therapeutic monitoring assays for HIV disease through the State HIV Therapeutic Monitoring Program.

Existing law authorizes the department, under the Medi-Cal program, to enter into specified contracts for various products and



services. Under these provisions, the department is considered the purchaser, but not the dispenser or distributor, of prescribed drugs.

This bill would provide similar authority to the department under the genetically handicapped person's program and the California Children's Services program, with respect to factor replacement therapies and various product-type health care services and laboratory services.

Existing law requires the State Department of Health Services to grant funds for up to 3 years per grant, to eligible private, nonprofit, community-based primary care clinics for the purpose of establishing and maintaining a health services program for seasonal agricultural and migratory workers and their families and specified rural health services and development projects.

This bill would require that the grants shall be for a minimum of 3 years, and would make the application of the grant extension retroactive to funds appropriated in the 2002 Budget Act.

Unless otherwise specified, funds appropriated in the Budget Act are available for expenditure in the year for which the Budget Act is enacted. By extending the period of the grants for which funds have been appropriated, this bill would result in an appropriation.

Existing law requires that all health facilities, except those owned and operated by the state, be charged each year a designated fee established in accordance with certain requirements, by the Office of Statewide Health Planning and Development to pay for certain functions required to be performed by the office. Existing law authorizes the State Department of Health Services to expend \$200,000 of the fees collected pursuant to this provision for use in the 2002–03 fiscal year for data collection on, analysis of, and reporting on, maternal and perinatal outcomes, if funds are appropriated in the Budget Act for that purpose.

This bill would delete reference to the 2002–03 fiscal year, thereby extending indefinitely the authority to expend \$200,000 of the fees collected as described above.

Existing law establishes the Healthy Families Program, administered by the Managed Risk Medical Insurance Board, to arrange for the provision of health, dental, and vision services to eligible children pursuant to a federal program, entitled the State Children's Health Insurance Program. Eligibility requirements include being a child in a family with a household income equal to or less than 200% of the federal poverty level.



This bill would, as an alternative to this eligibility requirement, provide eligibility, as prescribed, for a child under the age of 2 years delivered by a mother enrolled in the Access to Infants and Mothers Program. The bill would provide that a child eligible under this provision shall be deemed eligible at birth, and would provide that these provisions may only be implemented to the extent funds are appropriated in the annual Budget Act or other statute.

Existing law, until July 1, 2003, authorizes the department, in conjunction with the Managed Risk Medical Insurance Board, the County Medical Services Program board, and the Rural Health Policy Council, to develop and administer up to 5 demonstration projects in rural areas that are likely to contain a significant level of uninsured children, including seasonal and migratory worker dependents.

This bill would delete the July 1, 2003, inoperative date, thereby extending the operation of this provision indefinitely.

Existing law establishes the Medi-Cal-to-Healthy Families Bridge Benefits Program to provide any child who meets certain criteria with 2 months of health care benefits in order to provide the child with an opportunity to apply for the Healthy Families Program.

This bill would decrease the health care benefits under this provision from 2 months to one month, and would restore the benefits to a 2-month period commencing on the implementation of the Healthy Families waiver required to be sought from the federal government, under existing law.

Existing law specifies that the provisions establishing the Healthy Families Program shall be repealed on January 1, 2004.

This bill would repeal this provision, thereby extending the Healthy Families Program indefinitely.

Existing law creates the Healthy Families Fund, which is continuously appropriated to the board for the purposes of funding the Healthy Families Program. Because this bill would continue expenditures from this continuously appropriated fund by extending the Healthy Families Program indefinitely, this bill would make an appropriation.

Existing law establishes the Access for Infants and Mothers (AIM) Program, administered by the Managed Risk Medical Insurance Board.

Existing law requires the board to contract with a variety of health plans and types of health care service delivery systems in order to offer subscribers a choice of plans, providers, and types of service delivery and to negotiate or arrange for stop-loss insurance coverage.

This bill, instead, would authorize the board to perform these activities.

Existing law provides that participating health plans contracting with the board under the AIM are required to provide benefits and coverage only as determined by the board pursuant to its authority and exempts these plans from complying with certain other provisions.

This bill would delete the exemption provided for participating health plans contracting with the board.

Existing law establishes the Major Risk Medical Insurance Board Access for Infants and Mothers Advisory Panel to advise the board on all policies, regulations, operations, and implementation of the AIM Program.

This bill would change the name of the panel to the Managed Risk Medical Insurance Board Access for Infants and Mothers Advisory Panel.

Existing law provides that a person is not eligible to participate in the AIM Program if the person is a Medi-Cal or Medicare beneficiary at the time of application.

This bill would, instead, provide that a person is not eligible to participate in the AIM Program if the person is eligible for Medi-Cal without a share of cost or Medicare at the time of application.

Existing law authorizes coverage under the AIM Program for any of a subscriber's children at a monthly premium sufficient to fully cover the cost of coverage for these children, as determined by the board. Existing law provides a minimum coverage to AIM Program subscribers during one pregnancy, and for 60 days thereafter, and to children less than 2 years of age who were born of a pregnancy covered under the program.

This bill would limit the coverage of the latter category to children less than 2 years of age who were born of a pregnancy covered under the program to a woman enrolled in the program before July 1, 2004. This bill would delete the provision authorizing coverage for any of a subscriber's children, as prescribed.

Existing law creates the Children's Health Initiative Matching Fund in the State Treasury, which is administered by the Managed Risk Medical Insurance Board, in collaboration with the State Department of Health Services, for the purpose of providing matching state funds and local funds received by the fund through intergovernmental transfers to a county agency, a local initiative, or a county organized health system to provide health insurance coverage to certain children in low-income households who do not qualify for health care benefits



through the Healthy Families Program or Medi-Cal. Existing law, the California Public Records Act, exempts certain records and information from being disclosed.

This bill would instead create the County Health Initiative Matching Fund in the State Treasury for those purposes. The bill would authorize the board to enter into contracts and to issue rules and regulations on an emergency basis. The bill would require the Governor to apply for waivers or file state plan amendments in order to obtain federal financial participation for specified projects. The bill would exempt records of the board related to the fund from disclosure. The bill would make related changes.

Existing law establishes procedures for making an application for the release of a person who has been committed to a state hospital or other treatment facility upon the ground that sanity has been restored.

This bill would specify that any person to whom those procedures apply and who petitions or is recommended for restoration of sanity may not be placed in a forensic conditional release program for one year, and a finding of restoration of sanity may be made without the person being in a forensic conditional release program for one year. The bill would also provide that if a finding of restoration of sanity is made, the person shall be transferred to the custody of the California Department of Corrections to serve the term of imprisonment remaining or shall be transferred to the appropriate court for imposition of the sentence that is pending, whichever is applicable.

Existing law contains provisions relating to the setting of reimbursement rates for community treatment facilities, as defined.

Existing law authorizes up to 400 community treatment facility beds statewide pursuant to the above provisions of law, and anticipates a phased-in implementation of community treatment facilities, with an average monthly community treatment facility caseload, by fiscal year, as specified.

This bill would increase that community treatment facility caseload number to 175 for the 2003–04 fiscal year.

Existing law requires the State Department of Developmental Services to contract, for a maximum contract term of 3 years, with a nonprofit agency or agencies to provide clients' rights advocacy services.

This bill would extend the maximum contract term to 5 years.



Under the Lanterman Developmental Disabilities Services Act, administered by the State Department of Developmental Services, services are provided to persons with developmental disabilities.

This bill would define “substantial disability” for purposes of the act.

Existing law requires the State Department of Developmental Services to enter into contracts with nonprofit entities to operate regional centers for the provision of services and supports to persons with developmental disabilities.

This bill would require the department, after consultation with stakeholder groups, to develop a system of enrollment fees, copayments, or both, to be assessed against the parents of each child between the ages of 3 and 17 years, who lives in the parent’s home and receives services purchased through a regional center.

The bill would also require the department, after consultation with stakeholder groups to submit a detailed plan that meets certain criteria to the Legislature, on or before April 1, 2004, for implementing a parental copayment system applicable to certain families who have children receiving services purchased through a regional center, and would prohibit the plan from being implemented without subsequent statutory authorization by the Legislature.

Existing law requires, until July 1, 2004, the State Department of Developmental Services to determine the amount of unallocated reduction that each regional center shall make in its purchase-of-service budget, and requires each regional center to take specified actions upon the department’s determination.

This bill would extend this provision to July 1, 2005.

Existing law requires that regional centers contracting with the State Department of Developmental Services to provide services for certain adults with developmental disabilities shall be required to establish specified service coordinator-to-consumer ratios. To ensure that caseload ratios are maintained under this provision, each regional center is required to provide services coordinator caseload data that includes certain information to the department in September and March of each fiscal year.

This bill would revise the service coordinator-to-consumer ratios, as prescribed. The bill would also require that the services coordinator caseload data be provided, instead, annually in each fiscal year and would revise the information that the data is required to include.

Existing law provides for initial intake and assessment services by regional centers to determine the level of service for which an applicant

is eligible, and requires that, if assessment is needed, it shall be performed within a certain time period. If assessment is needed, prior to July 1, 2003, the assessment is required to be performed within 120 days following initial intake.

This bill would extend that date to July 1, 2004.

Existing law requires the Director of Developmental Services to establish a process for setting rates or establish rates of state payment for various services purchased by regional centers.

The bill would prohibit a regional center, during the 2003–04 fiscal year, from approving any service level for a residential service provider if the approval would result in an increase in the rate to be paid to the provider that is greater than the rate that is in effect on or after June 30, 2003, unless certain conditions are met.

The bill would also prohibit, for the 2003–04 fiscal year, a regional center from paying providers of certain services reimbursement rates that exceed the rates in effect on June 30, 2003, except under specified circumstances.

The bill would also prohibit the department, during the 2003–04 fiscal year, from establishing any permanent payment rate for a community-based day program or in-home respite service agency provider that has a temporary payment rate in effect on June 30, 2003, if the rate would be greater than the rate in effect on June 30, 2003, except under specified circumstances.

Existing law, until January 1, 2004, requires the State Department of Developmental Services to conduct a pilot project under which funds are allocated for local self-determination pilot programs that will enhance the ability of a consumer and his or her family to control the decisions and resources required to meet all or some of the objectives in his or her individual program plan. Under these provisions, the department is required to allocate funds for pilot programs in 3 regional center catchment areas and, to the extent possible, test a variety of mechanisms provided for in existing law.

This bill would delete the January 1, 2004, repeal date, thereby extending the operation of this provision indefinitely. This bill would, instead, require the department to allow the continuation of the existing pilot project in 5 specified regional center catchment areas and to expand the pilot project to other regional center catchment areas when consistent with federal approval of a self-determination waiver.

Existing law also provides that for the 2002–03 fiscal year only, a regional center may not expend any purchase of service funds for the

startup of any new program unless the expenditure is necessary to protect the consumer's health or safety or because of other extraordinary circumstances, and the department has granted prior written authorization for the expenditure, with certain exceptions.

This bill would extend that limitation to include the 2003–04 fiscal year.

The federal medicaid program provides for federal financial participation for state medical assistance programs that meet federal standards. This state's version of the medicaid program is known as the California Medical Assistance Program, or the Medi-Cal program.

Federal law permits the payment of federal medicaid funds to participating states for benefits provided to recipients by, among other methods, enrollment in managed care plans, including mental health plans.

Existing law requires the State Department of Mental Health to implement mental health managed care services for Medi-Cal beneficiaries. Existing law requires the department to adopt emergency regulations to implement provisions relating to sanctions that the department may impose under these provisions.

This bill would delete those provisions regarding emergency regulations, and would specify that certain emergency regulations would remain in effect only until July 1, 2004, unless made permanent by the department.

Existing law provides for the Medi-Cal program, administered by the State Department of Health Services, pursuant to which medical benefits are provided to public assistance recipients and certain other low-income persons.

Under existing law, the state is required to provide an additional 12-month period of transitional Medi-Cal eligibility to persons aged 19 years and older who have received 12 months of transitional Medi-Cal eligibility and who continue to meet specified transitional Medi-Cal eligibility requirements.

This bill would terminate these benefits on October 1, 2003, but would provide that persons receiving these benefits on September 30, 2003, shall be provided with notice of this termination and have their Medi-Cal eligibility redetermined.

By requiring each county to redetermine the Medi-Cal eligibility of certain Medi-Cal recipients, the bill would create a state-mandated local program.



Existing law requires the department to develop an electronic application to serve as the application for preenrollment into the Medi-Cal program or the Healthy Families Program and to also serve as an application for the Child Health and Disability Prevention program.

This bill would authorize the department to also use the electronic application developed pursuant to these provisions as a means to enroll newborns into the Medi-Cal program.

Existing law provides that the beneficiary or any person on behalf of the beneficiary who has paid for health care services otherwise covered by the Medi-Cal program received by the beneficiary shall be entitled to a return from the provider of any part of the payment that is paid to the provider in certain circumstances where the services were rendered prior to the receipt of the beneficiary's Medi-Cal card and was reimbursed to the provider by the Medi-Cal program, as specified.

This bill would limit that requirement to medically necessary health care services. It would apply, instead, to certain circumstances where the services were rendered during the 90-day period prior to the beneficiary's application for his or her Medi-Cal card or after application for, but prior to receipt of the Medi-Cal card. It would require the department to ensure payment to a beneficiary by a provider, and would specify enforcement action the department shall take if the provider fails to or refuses to reimburse the beneficiary.

Existing law authorizes the department, by regulation, to adopt measures to prevent or curtail Medi-Cal fraud and abuse.

This bill would authorize the department to limit, for 18 months or less, the codes for which any provider may bill, or for which reimbursement to any person or entity may be made by, the Medi-Cal program or other health care programs administered by the department if the department determines that excessive services or billings, or abuse, has occurred or a health professional is precluded, by the imposition of certain limitations, from performing services reimbursed by the Medi-Cal program or other health care programs administered by the department.

Existing law authorizes the department to prescribe the policies for the administration of the Medi-Cal program and limit the rates of payment for health care services, consistent with state law.

This bill would require the department to establish a list of covered services and maximum allowable reimbursement rates for prosthetic and orthotic appliances and durable medical equipment and publish the



list in provider manuals. The bill would require the repeal of related nonconforming regulations. It would also authorize the department to implement utilization controls through the establishment of guidelines, protocols, algorithms, or criteria for medical equipment, and enteral formulas, and to publish this information on the pharmacy and medical provider manuals.

This bill would prohibit an assistive device and sickroom supply dealer from billing the Medi-Cal program for prosthetic and orthotic appliances, and would prohibit a pharmacy from doing so unless the pharmacy is certified by the National Community of Pharmacists Association and the appliances have been approved by the department.

This bill would specify the maximum reimbursement for clinical laboratory or laboratory services, durable medical equipment, certain prosthetic and orthotic appliances, and blood factors.

Existing law establishes a schedule of benefits that may be provided under the Medi-Cal program.

This bill would require the department to apply for a waiver of federal law to test the efficacy of providing a disease management benefit to specified beneficiaries under the Medi-Cal program.

Existing law provides for the payment of providers under the Medi-Cal program.

Existing law establishes the Health Care Deposit Fund, as an appropriated fund, from which are made expenditures of state, county, and federal funds for health care and administration under the Medi-Cal program.

This bill would provide that, commencing with the 2004–05 fiscal year, expenditures for Medi-Cal services and for state and county administration costs included in the department’s budget shall be charged against the appropriation for the fiscal year in which the billing is paid. The bill would also provide that, commencing July 1, 2004, all 2002–03 fiscal year and prior accrued obligations of the Health Care Deposit Fund shall become obligations of the 2004–05 fiscal year and all moneys available from the 2002–03 fiscal year and prior appropriations shall be reappropriated for the 2004–05 fiscal year for that purpose.

Existing law authorizes the Director of Health Services to enter into contracts with managed care plans to provide services under the Medi-Cal program.

This bill would authorize the State Department of Health Services to impose, annually, a quality improvement fee on the capitation payments



paid to a Medi-Cal managed care plan, with the fees to be used to provide capitation rate increases for Medi-Cal managed care plan's quality improvement. This provision would only be implemented if approval for federal financial participation is obtained.

Existing law provides for the development of Medi-Cal mental health plans and requires the State Department of Mental Health to ensure that these plans contain certain processes and components.

This bill would require the department to establish a process for second level treatment authorization request appeals to review and resolve disputes between mental health plans and hospitals.

The Medi-Cal program is partially governed and funded pursuant to the federal medicaid program.

Pursuant to an inoperative provision that is repealed on January 1, 2007, the department is required, upon federal approval of a medicaid state plan amendment, to provide a supplemental rate adjustment to the Medi-Cal reimbursement rate for specific nursing facilities, intermediate care facilities/developmentally disabled, intermediate care facilities/developmentally disabled-habilitative, intermediate care facilities/developmentally disabled-nursing, and pediatric subacute units which have a collectively bargained contract or a comparable legally binding, written commitment to increase salaries, wages, or benefits for nonmanagerial, nonadministrative, noncontract staff.

This bill would, instead, express the intent of the Legislature that this provision be implemented immediately, and would require the department, for the period commencing February 1, 2002, to July 31, 2004, inclusive, to pay any supplemental rate adjustment permitted under this provision to the extent that a facility submits a rate adjustment request in accordance with specified requirements and the request is approved by the department.

This bill would specify that amounts appropriated in the 2003 Budget Act for purposes of this provision may be expended for supplemental rate adjustments relating to periods in the 2002–03 fiscal year.

This bill would make these provisions inoperative on August 1, 2004.

Existing law establishes a schedule of benefits that may be provided under the Medi-Cal program.

This bill would require the department to apply for a waiver of federal law to test the efficacy of providing a disease management benefit to specified beneficiaries under the Medi-Cal program.

Existing law requires the department to establish and maintain a plan whereby costs for county administration of the determination of

eligibility for benefits under the Medi-Cal program will be effectively controlled within the amounts annually appropriated for that administration.

Existing law requires counties, in administering the Medi-Cal eligibility process, to meet certain performance standards, including the performance of timely annual redeterminations, and requires that 90% of the annual redeterminations be commenced by the anniversary date.

This bill, instead, would require that 90% of the annual redetermination forms be mailed to the beneficiary by the anniversary date.

Existing law provides for the payment of providers under the Medi-Cal program.

Existing law establishes the Health Care Deposit Fund, as an appropriated fund, from which are made expenditures of state, county, and federal funds for health care and administration under the Medi-Cal program.

This bill would provide that, commencing with the 2004–05 fiscal year, expenditures for Medi-Cal services and for state and county administration costs included in the department’s budget shall be charged against the appropriation for the fiscal year in which the billing is paid. The bill would also provide that, commencing July 1, 2004, all 2002–03 fiscal year and prior accrued obligations of the Health Care Deposit Fund shall become obligations of the 2004–05 fiscal year and all moneys available from the 2002–03 fiscal year and prior appropriations shall be reappropriated for the 2004–05 fiscal year for that purpose.

Existing law authorizes the Director of Health Services to enter into contracts with managed care plans to provide services under the Medi-Cal program.

This bill would authorize the State Department of Health Services to impose, annually, a quality improvement fee on the capitation payments paid to a Medi-Cal managed care plan, with the fees to be used to provide capitation rate increases for Medi-Cal managed care plan’s quality improvement. This provision would only be implemented if approval for federal financial participation is obtained.

Existing law provides for the development of Medi-Cal mental health plans and requires the State Department of Mental Health to ensure that these plans contain certain processes and components.



This bill would require the department to establish a process for second level treatment authorization request appeals to review and resolve disputes between mental health plans and hospitals.

Existing law provides that the board of supervisors of a county that contracted with the State Department of Health Services pursuant to a specified provision of law during the 1990–91 fiscal year and any county with a population under 300,000, as determined in accordance with the 1990 decennial census, by adopting a resolution to that effect, may elect to participate in the County Medical Services Program for state administration of health care services to eligible persons in the county.

This bill would revise, for the 2003–04 fiscal year, state and counties financial responsibilities for certain increases in costs in the County Medical Services Program.

This bill would reallocate certain amounts appropriated in the Budget Act of 2003 from the Cigarette and Tobacco Products Surtax Fund.

This bill would authorize the Medical Insurance Board to adopt emergency regulations to implement various provisions of the bill.

This bill would prohibit the State Department of Health Services from implementing limits on laboratory services as prescribed.

This bill would require the State Department of Health Services to require contractors and grantees under the Office of Family Planning, Male Involvement Program, and Information and Education Program, to establish, as prescribed, a clinical service linkage to the Family PACT program.

The bill would authorize the State Department of Health Services to adopt emergency regulations to implement applicable provisions of the bill.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement, including the creation of a State Mandates Claims Fund to pay the costs of mandates that do not exceed \$1,000,000 statewide and other procedures for claims whose statewide costs exceed \$1,000,000.

This bill would provide that with regard to certain mandates no reimbursement is required by this act for a specified reason.

With regard to any other mandates, this bill would provide that, if the Commission on State Mandates determines that the bill contains costs



so mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

This bill would declare that it is to take effect immediately as an urgency statute.

~~This bill would express the intent of the Legislature to enact statutory changes relating to the Budget Act of 2003.~~

Vote: ~~majority~~ ^{2/3}. Appropriation: ~~no~~ yes. Fiscal committee: ~~no~~ yes. State-mandated local program: ~~no~~ yes.

The people of the State of California do enact as follows:

1 ~~SECTION 1. It is the intent of the Legislature to enact~~
2 ~~statutory changes relating to the Budget Act of 2003.~~

3 ~~SECTION 1. Section 6254 of the Government Code is~~
4 ~~amended to read:~~

5 6254. Except as provided in Sections 6254.7 and 6254.13,
6 nothing in this chapter shall be construed to require disclosure of
7 records that are any of the following:

8 (a) Preliminary drafts, notes, or interagency or intra-agency
9 memorandums that are not retained by the public agency in the
10 ordinary course of business, provided that the public interest in
11 withholding those records clearly outweighs the public interest in
12 disclosure.

13 (b) Records pertaining to pending litigation to which the public
14 agency is a party, or to claims made pursuant to Division 3.6
15 (commencing with Section 810), until the pending litigation or
16 claim has been finally adjudicated or otherwise settled.

17 (c) Personnel, medical, or similar files, the disclosure of which
18 would constitute an unwarranted invasion of personal privacy.

19 (d) Contained in or related to any of the following:

20 (1) Applications filed with any state agency responsible for the
21 regulation or supervision of the issuance of securities or of
22 financial institutions, including, but not limited to, banks, savings
23 and loan associations, industrial loan companies, credit unions,
24 and insurance companies.

25 (2) Examination, operating, or condition reports prepared by,
26 on behalf of, or for the use of, any state agency referred to in
27 paragraph (1).

(3) Preliminary drafts, notes, or interagency or intra-agency communications prepared by, on behalf of, or for the use of, any state agency referred to in paragraph (1).

(4) Information received in confidence by any state agency referred to in paragraph (1).

(e) Geological and geophysical data, plant production data, and similar information relating to utility systems development, or market or crop reports, that are obtained in confidence from any person.

(f) Records of complaints to, or investigations conducted by, or records of intelligence information or security procedures of, the office of the Attorney General and the Department of Justice, and any state or local police agency, or any investigatory or security files compiled by any other state or local police agency, or any investigatory or security files compiled by any other state or local agency for correctional, law enforcement, or licensing purposes, except that state and local law enforcement agencies shall disclose the names and addresses of persons involved in, or witnesses other than confidential informants to, the incident, the description of any property involved, the date, time, and location of the incident, all diagrams, statements of the parties involved in the incident, the statements of all witnesses, other than confidential informants, to the victims of an incident, or an authorized representative thereof, an insurance carrier against which a claim has been or might be made, and any person suffering bodily injury or property damage or loss, as the result of the incident caused by arson, burglary, fire, explosion, larceny, robbery, carjacking, vandalism, vehicle theft, or a crime as defined by subdivision (c) of Section 13960, unless the disclosure would endanger the safety of a witness or other person involved in the investigation, or unless disclosure would endanger the successful completion of the investigation or a related investigation. However, nothing in this division shall require the disclosure of that portion of those investigative files that reflect the analysis or conclusions of the investigating officer.

Notwithstanding any other provision of this subdivision, state and local law enforcement agencies shall make public the following information, except to the extent that disclosure of a particular item of information would endanger the safety of a person involved in an investigation or would endanger the

1 successful completion of the investigation or a related
2 investigation:

3 (1) The full name and occupation of every individual arrested
4 by the agency, the individual's physical description including date
5 of birth, color of eyes and hair, sex, height and weight, the time and
6 date of arrest, the time and date of booking, the location of the
7 arrest, the factual circumstances surrounding the arrest, the
8 amount of bail set, the time and manner of release or the location
9 where the individual is currently being held, and all charges the
10 individual is being held upon, including any outstanding warrants
11 from other jurisdictions and parole or probation holds.

12 (2) Subject to the restrictions imposed by Section 841.5 of the
13 Penal Code, the time, substance, and location of all complaints or
14 requests for assistance received by the agency and the time and
15 nature of the response thereto, including, to the extent the
16 information regarding crimes alleged or committed or any other
17 incident investigated is recorded, the time, date, and location of
18 occurrence, the time and date of the report, the name and age of the
19 victim, the factual circumstances surrounding the crime or
20 incident, and a general description of any injuries, property, or
21 weapons involved. The name of a victim of any crime defined by
22 Section 220, 261, 261.5, 262, 264, 264.1, 273a, 273d, 273.5, 286,
23 288, 288a, 289, 422.6, 422.7, 422.75, or 646.9 of the Penal Code
24 may be withheld at the victim's request, or at the request of the
25 victim's parent or guardian if the victim is a minor. When a person
26 is the victim of more than one crime, information disclosing that
27 the person is a victim of a crime defined by Section 220, 261,
28 261.5, 262, 264, 264.1, 273a, 273d, 286, 288, 288a, 289, 422.6,
29 422.7, 422.75, or 646.9 of the Penal Code may be deleted at the
30 request of the victim, or the victim's parent or guardian if the
31 victim is a minor, in making the report of the crime, or of any crime
32 or incident accompanying the crime, available to the public in
33 compliance with the requirements of this paragraph.

34 (3) Subject to the restrictions of Section 841.5 of the Penal
35 Code and this subdivision, the current address of every individual
36 arrested by the agency and the current address of the victim of a
37 crime, where the requester declares under penalty of perjury that
38 the request is made for a scholarly, journalistic, political, or
39 governmental purpose, or that the request is made for investigation
40 purposes by a licensed private investigator as described in Chapter

1 11.3 (commencing with Section 7512) of Division 3 of the
2 Business and Professions Code, except that the address of the
3 victim of any crime defined by Section 220, 261, 261.5, 262, 264,
4 264.1, 273a, 273d, 273.5, 286, 288, 288a, 289, 422.6, 422.7,
5 422.75, or 646.9 of the Penal Code shall remain confidential.
6 Address information obtained pursuant to this paragraph shall not
7 be used directly or indirectly to sell a product or service to any
8 individual or group of individuals, and the requester shall execute
9 a declaration to that effect under penalty of perjury.

10 (g) Test questions, scoring keys, and other examination data
11 used to administer a licensing examination, examination for
12 employment, or academic examination, except as provided for in
13 Chapter 3 (commencing with Section 99150) of Part 65 of the
14 Education Code.

15 (h) The contents of real estate appraisals or engineering or
16 feasibility estimates and evaluations made for or by the state or
17 local agency relative to the acquisition of property, or to
18 prospective public supply and construction contracts, until all of
19 the property has been acquired or all of the contract agreement
20 obtained. However, the law of eminent domain shall not be
21 affected by this provision.

22 (i) Information required from any taxpayer in connection with
23 the collection of local taxes that is received in confidence and the
24 disclosure of the information to other persons would result in
25 unfair competitive disadvantage to the person supplying the
26 information.

27 (j) Library circulation records kept for the purpose of
28 identifying the borrower of items available in libraries, and library
29 and museum materials made or acquired and presented solely for
30 reference or exhibition purposes. The exemption in this
31 subdivision shall not apply to records of fines imposed on the
32 borrowers.

33 (k) Records, the disclosure of which is exempted or prohibited
34 pursuant to federal or state law, including, but not limited to,
35 provisions of the Evidence Code relating to privilege.

36 (l) Correspondence of and to the Governor or employees of the
37 Governor's office or in the custody of or maintained by the
38 Governor's legal affairs secretary, provided that public records
39 shall not be transferred to the custody of the Governor's Legal
40 Affairs Secretary to evade the disclosure provisions of this chapter.

1 (m) In the custody of or maintained by the Legislative Counsel,
2 except those records in the public database maintained by the
3 Legislative Counsel that are described in Section 10248.

4 (n) Statements of personal worth or personal financial data
5 required by a licensing agency and filed by an applicant with the
6 licensing agency to establish his or her personal qualification for
7 the license, certificate, or permit applied for.

8 (o) Financial data contained in applications for financing under
9 Division 27 (commencing with Section 44500) of the Health and
10 Safety Code, where an authorized officer of the California
11 Pollution Control Financing Authority determines that disclosure
12 of the financial data would be competitively injurious to the
13 applicant and the data is required in order to obtain guarantees
14 from the United States Small Business Administration. The
15 California Pollution Control Financing Authority shall adopt rules
16 for review of individual requests for confidentiality under this
17 section and for making available to the public those portions of an
18 application that are subject to disclosure under this chapter.

19 (p) Records of state agencies related to activities governed by
20 Chapter 10.3 (commencing with Section 3512), Chapter 10.5
21 (commencing with Section 3525), and Chapter 12 (commencing
22 with Section 3560) of Division 4 of Title 1, that reveal a state
23 agency's deliberative processes, impressions, evaluations,
24 opinions, recommendations, meeting minutes, research, work
25 products, theories, or strategy, or that provide instruction, advice,
26 or training to employees who do not have full collective bargaining
27 and representation rights under these chapters. Nothing in this
28 subdivision shall be construed to limit the disclosure duties of a
29 state agency with respect to any other records relating to the
30 activities governed by the employee relations acts referred to in
31 this subdivision.

32 (q) Records of state agencies related to activities governed by
33 Article 2.6 (commencing with Section 14081), Article 2.8
34 (commencing with Section 14087.5), and Article 2.91
35 (commencing with Section 14089) of Chapter 7 of Part 3 of
36 Division 9 of the Welfare and Institutions Code, that reveal the
37 special negotiator's deliberative processes, discussions,
38 communications, or any other portion of the negotiations with
39 providers of health care services, impressions, opinions,
40 recommendations, meeting minutes, research, work product,

1 theories, or strategy, or that provide instruction, advice, or training
2 to employees.

3 Except for the portion of a contract containing the rates of
4 payment, contracts for inpatient services entered into pursuant to
5 these articles, on or after April 1, 1984, shall be open to inspection
6 one year after they are fully executed. In the event that a contract
7 for inpatient services that is entered into prior to April 1, 1984, is
8 amended on or after April 1, 1984, the amendment, except for any
9 portion containing the rates of payment, shall be open to inspection
10 one year after it is fully executed. If the California Medical
11 Assistance Commission enters into contracts with health care
12 providers for other than inpatient hospital services, those contracts
13 shall be open to inspection one year after they are fully executed.

14 Three years after a contract or amendment is open to inspection
15 under this subdivision, the portion of the contract or amendment
16 containing the rates of payment shall be open to inspection.

17 Notwithstanding any other provision of law, the entire contract
18 or amendment shall be open to inspection by the Joint Legislative
19 Audit Committee. The committee shall maintain the
20 confidentiality of the contracts and amendments until the time a
21 contract or amendment is fully open to inspection by the public.

22 (r) Records of Native American graves, cemeteries, and sacred
23 places maintained by the Native American Heritage Commission.

24 (s) A final accreditation report of the Joint Commission on
25 Accreditation of Hospitals that has been transmitted to the State
26 Department of Health Services pursuant to subdivision (b) of
27 Section 1282 of the Health and Safety Code.

28 (t) Records of a local hospital district, formed pursuant to
29 Division 23 (commencing with Section 32000) of the Health and
30 Safety Code, or the records of a municipal hospital, formed
31 pursuant to Article 7 (commencing with Section 37600) or Article
32 8 (commencing with Section 37650) of Chapter 5 of Division 3 of
33 Title 4 of this code, that relate to any contract with an insurer or
34 nonprofit hospital service plan for inpatient or outpatient services
35 for alternative rates pursuant to Section 10133 or 11512 of the
36 Insurance Code. However, the record shall be open to inspection
37 within one year after the contract is fully executed.

38 (u) (1) Information contained in applications for licenses to
39 carry firearms issued pursuant to Section 12050 of the Penal Code
40 by the sheriff of a county or the chief or other head of a municipal

1 police department that indicates when or where the applicant is
2 vulnerable to attack or that concerns the applicant's medical or
3 psychological history or that of members of his or her family.

4 (2) The home address and telephone number of peace officers,
5 judges, court commissioners, and magistrates that are set forth in
6 applications for licenses to carry firearms issued pursuant to
7 Section 12050 of the Penal Code by the sheriff of a county or the
8 chief or other head of a municipal police department.

9 (3) The home address and telephone number of peace officers,
10 judges, court commissioners, and magistrates that are set forth in
11 licenses to carry firearms issued pursuant to Section 12050 of the
12 Penal Code by the sheriff of a county or the chief or other head of
13 a municipal police department.

14 (v) (1) Records of the Major Risk Medical Insurance Program
15 related to activities governed by Part 6.3 (commencing with
16 Section 12695) and Part 6.5 (commencing with Section 12700) of
17 Division 2 of the Insurance Code, and that reveal the deliberative
18 processes, discussions, communications, or any other portion of
19 the negotiations with health plans, or the impressions, opinions,
20 recommendations, meeting minutes, research, work product,
21 theories, or strategy of the board or its staff, or records that provide
22 instructions, advice, or training to employees.

23 (2) (A) Except for the portion of a contract that contains the
24 rates of payment, contracts for health coverage entered into
25 pursuant to Part 6.3 (commencing with Section 12695) or Part 6.5
26 (commencing with Section 12700) of Division 2 of the Insurance
27 Code, on or after July 1, 1991, shall be open to inspection one year
28 after they have been fully executed.

29 (B) In the event that a contract for health coverage that is
30 entered into prior to July 1, 1991, is amended on or after July 1,
31 1991, the amendment, except for any portion containing the rates
32 of payment, shall be open to inspection one year after the
33 amendment has been fully executed.

34 (3) Three years after a contract or amendment is open to
35 inspection pursuant to this subdivision, the portion of the contract
36 or amendment containing the rates of payment shall be open to
37 inspection.

38 (4) Notwithstanding any other provision of law, the entire
39 contract or amendments to a contract shall be open to inspection
40 by the Joint Legislative Audit Committee. The committee shall

maintain the confidentiality of the contracts and amendments thereto, until the contract or amendments to a contract is open to inspection pursuant to paragraph (3).

(w) (1) Records of the Major Risk Medical Insurance Program related to activities governed by Chapter 14 (commencing with Section 10700) of Part 2 of Division 2 of the Insurance Code, and that reveal the deliberative processes, discussions, communications, or any other portion of the negotiations with health plans, or the impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy of the board or its staff, or records that provide instructions, advice, or training to employees.

(2) Except for the portion of a contract that contains the rates of payment, contracts for health coverage entered into pursuant to Chapter 14 (commencing with Section 10700) of Part 2 of Division 2 of the Insurance Code, on or after January 1, 1993, shall be open to inspection one year after they have been fully executed.

(3) Notwithstanding any other provision of law, the entire contract or amendments to a contract shall be open to inspection by the Joint Legislative Audit Committee. The committee shall maintain the confidentiality of the contracts and amendments thereto, until the contract or amendments to a contract is open to inspection pursuant to paragraph (2).

(x) Financial data contained in applications for registration, or registration renewal, as a service contractor filed with the Director of the Department of Consumer Affairs pursuant to Chapter 20 (commencing with Section 9800) of Division 3 of the Business and Professions Code, for the purpose of establishing the service contractor's net worth, or financial data regarding the funded accounts held in escrow for service contracts held in force in this state by a service contractor.

(y) (1) Records of the Managed Risk Medical Insurance Board related to activities governed by Part 6.2 (commencing with Section 12693) or Part 6.4 (commencing with Section 12699.50) of Division 2 of the Insurance Code, and that reveal the deliberative processes, discussions, communications, or any other portion of the negotiations with health plans, or the impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy of the board or its staff, or records that provide instructions, advice, or training to employees.

1 (2) (A) Except for the portion of a contract that contains the
2 rates of payment, contracts entered into pursuant to Part 6.2
3 (commencing with Section 12693) or Part 6.4 (commencing with
4 Section 12699.50) of Division 2 of the Insurance Code, on or after
5 January 1, 1998, shall be open to inspection one year after they
6 have been fully executed.

7 (B) In the event that a contract entered into pursuant to Part 6.2
8 (commencing with Section 12693) or Part 6.4 (commencing with
9 Section 12699.50) of Division 2 of the Insurance Code is amended,
10 the amendment shall be open to inspection one year after the
11 amendment has been fully executed.

12 (3) Three years after a contract or amendment is open to
13 inspection pursuant to this subdivision, the portion of the contract
14 or amendment containing the rates of payment shall be open to
15 inspection.

16 (4) Notwithstanding any other provision of law, the entire
17 contract or amendments to a contract shall be open to inspection
18 by the Joint Legislative Audit Committee. The committee shall
19 maintain the confidentiality of the contracts and amendments
20 thereto until the contract or amendments to a contract are open to
21 inspection pursuant to paragraph (2) or (3).

22 (5) *The exemption from disclosure provided pursuant to this*
23 *subdivision for the contracts, deliberative processes, discussions,*
24 *communications, negotiations with health plans, impressions,*
25 *opinions, recommendations, meeting minutes, research, work*
26 *product, theories, or strategy of the board or its staff shall also*
27 *apply to the contracts, deliberative processes, discussions,*
28 *communications, negotiations with health plans, impressions,*
29 *opinions, recommendations, meeting minutes, research, work*
30 *product, theories, or strategy of applicants pursuant to Part 6.4*
31 *(commencing with Section 12699.50) of Division 2 of the*
32 *Insurance Code.*

33 (z) Records obtained pursuant to paragraph (2) of subdivision
34 (c) of Section 2891.1 of the Public Utilities Code.

35 (aa) A document prepared by a local agency that assesses its
36 vulnerability to terrorist attack or other criminal acts intended to
37 disrupt the public agency's operations and that is for distribution
38 or consideration in a closed session.

1 Nothing in this section prevents any agency from opening its
2 records concerning the administration of the agency to public
3 inspection, unless disclosure is otherwise prohibited by law.

4 Nothing in this section prevents any health facility from
5 disclosing to a certified bargaining agent relevant financing
6 information pursuant to Section 8 of the National Labor Relations
7 Act.

8 *SEC. 2. Section 13967 of the Government Code is repealed.*

9 ~~13967. (a) (1) The Governor's Budget shall specify the~~
10 ~~estimated amount in the Restitution Fund that is in excess of the~~
11 ~~amount needed to pay claims pursuant to this chapter, to pay~~
12 ~~administrative costs for increasing restitution funds, and to~~
13 ~~maintain a prudent reserve.~~

14 ~~(2) It is the intent of the Legislature that, notwithstanding~~
15 ~~Section 13963, funds be appropriated in the annual Budget Act to~~
16 ~~the State Department of Mental Health from those funds that are~~
17 ~~determined to be in excess of the amount needed pursuant to~~
18 ~~paragraph (1), for the purposes of this section.~~

19 ~~(b) Notwithstanding any other provision of law, moneys in the~~
20 ~~Restitution Fund appropriated in the annual Budget Act pursuant~~
21 ~~to subdivision (a) may be used to fund programs and activities~~
22 ~~operated by the State Department of Mental Health, that address~~
23 ~~the problem of unequal protection for, and unequal services to,~~
24 ~~crime victims with disabilities.~~

25 ~~(c) Programs and activities that may be funded pursuant to this~~
26 ~~section include all of the following, as they relate to persons with~~
27 ~~disabilities:~~

28 ~~(1) Identification of crime victims with disabilities.~~

29 ~~(2) Crime and violence prevention.~~

30 ~~(3) Improvement of access to victim's support and~~
31 ~~compensation.~~

32 ~~(4) Planning and activities by service provider organizations to~~
33 ~~address the reduction of crime.~~

34 ~~(5) Establishment of programs for personal safety, planning,~~
35 ~~and training.~~

36 ~~(6) Public information efforts.~~

37 ~~(7) Coordination with other federal and state agencies.~~

38 ~~(8) Training of staff.~~

39 ~~(9) Programs and activities that facilitate the building of~~
40 ~~partnerships between advocates and service providers and the~~

~~criminal justice system to assist crime victims with disabilities to identify and report crime, and assist them in navigating the criminal justice system; secure victim assistance for victims with disabilities; and assist the criminal justice system in investigating, prosecuting, and trying those cases.~~

~~(10) Any other program or activity related to crime victims with disabilities.~~

~~(d) Moneys appropriated from the Restitution Fund may also be used for the evaluation of the effectiveness of the programs and activities funded pursuant to this section.~~

SEC. 3. Section 16531.1 of the Government Code is amended to read:

16531.1. (a) Notwithstanding any other provision of law and without regard to fiscal year, if the annual State Budget is not enacted by June 30 of any fiscal year preceding the fiscal year to which the budget would apply *or there is a deficiency in the Medi-Cal budget during any fiscal year*, both of the following shall occur:

(1) The Controller shall annually transfer from the General Fund, in the form of one or more loans, an amount not to exceed a cumulative total of one billion dollars (\$1,000,000,000) in any fiscal year, to the Medical Providers Interim Payment Fund, which is hereby created in the State Treasury. Notwithstanding Section 13340 of the Government Code, the Medical Providers Interim Payment Fund is hereby continuously appropriated for the purpose of making payments to Medi-Cal providers, providers of services under Chapter 6 (commencing with Section 120950) of Part 4 of Division 105 of the Health and Safety Code, and providers of services under Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code, for services provided on or after July 1 of the fiscal year for which no budget has been enacted and before September 1 of that year *or for the purpose of making payments to Medi-Cal providers, providers of services under Chapter 6 (commencing with Section 120950) of Part 4 of Division 105 of the Health and Safety Code, and providers of services under Division 4.5 (commencing with Section 4500), during the period in which the Medi-Cal Program has a deficiency*. Payments shall be made pursuant to this subdivision if both of the following conditions have been met:

(A) An invoice has been submitted for the services.

(B) Payment for the services is due and payable and the State Department of Health Services determines that payment would be valid.

(2) For any fiscal year to which this subdivision applies, there is hereby appropriated the sum of one billion dollars (\$1,000,000,000) from the Federal Trust Fund to the Medical Providers Interim Payment Fund.

(b) Upon the enactment of the annual Budget Act *or a deficiency bill* in any fiscal year to which subdivision (a) applies, the Controller shall transfer all expenditures and unexpended funds in the Medical Providers Interim Payment Fund to the appropriate Budget Act item.

(c) The amount of any loan made pursuant to subdivision (a) and for which moneys were expended from the Medical Providers Interim Payment Fund shall be repaid by debiting the appropriate Budget Act item in accordance with the procedure prescribed by the Department of Finance.

SEC. 4. Section 1266 of the Health and Safety Code is amended to read:

1266. (a) Each new and renewal application for a license for the health facilities listed below shall be accompanied by an annual fee as set forth below.

(1) The annual fee for a general acute care hospital, acute psychiatric hospital, special hospital, and chemical dependency recovery hospital, based on the number of licensed beds, is as follows:

1–49 beds	\$460 plus \$8 per bed
50–99 beds	\$850 plus \$8 per bed
100 or more beds	\$1,175 plus \$8 per bed

(2) The annual fee for a skilled nursing facility, intermediate care facility, and intermediate care facility/developmentally disabled, based on the number of licensed beds, is as follows:

1–59 beds	\$2,068 plus \$26 per bed
60–99 beds	\$2,543 plus \$26 per bed
100 or more beds	\$3,183 plus \$26 per bed

(3) The fees provided in this subdivision shall be adjusted, commencing July 1, 1983, as proposed in the state department's 1983–84 fiscal year Health Facility License Fee Report to the Legislature. Commencing July 1, 1984, fees provided in this subdivision shall be adjusted annually, as directed by the Legislature in the annual Budget Act.

(b) (1) By March 17 of each year, the State Department of Health Services shall make available to interested parties, upon request, information regarding the methodology and calculations used to determine the fee amounts specified in this section, the staffing and systems analysis required under subdivision (e), program costs associated with the licensing provisions of this division, and the actual numerical fee charges to be implemented on ~~June 30~~ July 1 of that year. ~~The~~ *This information shall specifically identify federal funds received, but not previously budgeted for, the licensing provisions of this division that are used to offset the amount of General Fund money to be recovered through license fees. The information shall also identify the purpose of federal funds received for any additional activities under the licensing provisions of this division that are not used to offset the amount of General Fund money.*

(2) The methodology and calculations used to determine the fee amounts shall result in fee levels in an amount sufficient to provide revenues equal to the sum of the following:

(A) The General Fund expenditures for the fiscal year ending on June 30 of that year, as specified in the Governor's proposed budget, less license fees estimated to be collected in that fiscal year by the licensing provisions of this division, excluding licensing fees collected pursuant to this section.

(B) The amount of federal funds budgeted for the fiscal year ending June 30 of that year for the licensing provisions of the division, less federal funds received or credited, or anticipated to be received or credited, during that fiscal year for that purpose.

The methodology for calculating the fee levels shall include an adjustment ~~which~~ *that* takes into consideration the actual amount of license fee revenue collected pursuant to this section for that prior fiscal year.

~~(2) The information specified in paragraph (1) shall specifically identify federal funds received, but not previously budgeted for, the licensing provisions of this division that are used~~

~~to offset the amount of General Fund money to be recovered through license fees. The information shall also identify the purpose of federal funds received for any additional activities under the licensing provisions of this division that are not used to offset the amount of General Fund money.~~

(3) *If the Budget Act provides for expenditures that differ by 5 percent from the Governor's proposed budget, the Department of Finance shall adjust the fees to reflect that difference and shall instruct the State Department of Health Services to publish those fees in accordance with subdivision (d).*

(c) The annual fees determined pursuant to this section shall be waived for any health facility conducted, maintained, or operated by this state or any state department, authority, bureau, commission, or officer, or by the Regents of the University of California, or by a local hospital district, city, county, or city and county.

(d) The department shall, ~~by July 30 of each year~~ *within 30 calendar days of the enactment of the Budget Act*, publish a list of actual numerical fee charges as adjusted pursuant to this section. This adjustment of fees, *any adjustment by the Department of Finance*, and the publication of the fee list shall not be subject to the *rulemaking* requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. If the published list of fees is higher than that made available to interested parties pursuant to subdivision (b), the affected health facilities may choose to pay the fee in the amount presented at the public hearing and to defer payment of the additional increment until 60 days after publication of the list of fees pursuant to this subdivision.

(e) Prior to the establishment of the annual fee, the ~~state~~ department shall prepare a staffing and systems analysis to ensure efficient and effective utilization of fees collected, proper allocation of departmental resources to licensing and certification activities, survey schedules, complaint investigations, enforcement and appeal activities, data collection and dissemination, surveyor training, and policy development.

The analysis under this subdivision shall be included in the information made available pursuant to subdivision (b), and shall include all of the following:

(1) The number of surveyors and administrative support personnel devoted to the licensing and certification of health care facilities.

(2) The percentage of time devoted to licensing and certification activities for the various types of health facilities.

(3) The number of facilities receiving full surveys and the frequency and number of followup visits.

(4) The number and timeliness of complaint investigations.

(5) Data on deficiencies and citations issued, and numbers of citation review conferences and arbitration hearings.

(6) Training courses provided for surveyors.

(7) Other applicable activities of the licensing and certification division.

The analysis shall also include recommendations for administrative changes to streamline and prioritize the survey process, complaint investigations, management information systems, word processing capabilities and effectiveness, consumer information system, and surveyor training.

The annual staffing and systems analysis shall be presented to the Health Care Advisory Committee and the Legislature prior to the establishment and adoption of the annual fee.

(f) The annual fee for a congregate living health facility shall initially, and until adjusted by the Legislature in a Budget Act, be based on the number of licensed beds as follows:

1–3 beds	\$ 800
4–6 beds	\$1,000
7–10 beds	\$1,200
11–15 beds	\$1,500
16 or more beds	\$1,700

Commencing July 1, 1991, fees provided in this subdivision shall be adjusted annually, as directed by the Legislature in the annual budget.

(g) The annual fee for a pediatric day health and respite care facility, as defined in Section 1760.2, shall initially, and until adjusted by the Legislature in a Budget Act, be based on the number of licensed beds as follows:

1	1–3 beds or clients	\$ 800
2	4–6 beds or clients	\$1,000
3	7–10 beds or clients	\$1,200
4	11–15 beds or clients	\$1,500
5	16 or more beds or clients	\$1,700 plus \$50 for each additional bed
6		or client over 16 beds or clients
7		

8 Commencing July 1, 1993, fees provided in this subdivision shall
9 be adjusted annually, as directed by the Legislature in the annual
10 Budget Act.

11 (h) The department shall, in consultation with affected
12 provider representatives, develop a specific proposal by July 1,
13 1995, to do all of the following:

14 (1) Revise the health facility licensure fee methodologies in a
15 manner that addresses the fee methodology and subsidy issues
16 described in the State Auditor Report Number 93020, Issues 2 and
17 3.

18 (2) Ensure the validity and reliability of the data systems used
19 to calculate the license fee.

20 (3) Address the subsidy of licensing and certification activities
21 regarding health facilities for which the annual license fee is
22 waived.

23 (4) Develop a licensing and certification special fund into
24 which all fees collected by the state department, for health facility
25 licensing, certification, regulation, and inspection duties,
26 functions, and responsibilities, shall be deposited.

27 *SEC. 4.5. Section 1316.5 of the Health and Safety Code, as*
28 *amended by Section 1 of Chapter 717 of the Statutes of 1998, is*
29 *amended to read:*

30 1316.5. (a) (1) Each health facility owned and operated by
31 the state offering care or services within the scope of practice of
32 a psychologist shall establish rules and medical staff bylaws that
33 include provisions for medical staff membership and clinical
34 privileges for clinical psychologists within the scope of their
35 licensure as psychologists, subject to the rules and medical staff
36 bylaws governing medical staff membership or privileges as the
37 facility shall establish. The rules and regulations shall not
38 discriminate on the basis of whether the staff member holds an
39 M.D., D.O., D.D.S., D.P.M., or doctoral degree in psychology
40 within the scope of the member's respective licensure. Each of

1 these health facilities owned and operated by the state shall
2 establish a staff comprised of physicians and surgeons, dentists,
3 podiatrists, psychologists, or any combination thereof, that shall
4 regulate the admission, conduct, suspension, or termination of the
5 staff appointment of psychologists employed by the health facility.

6 (2) With regard to the practice of psychology in health facilities
7 owned and operated by the state offering care or services within
8 the scope of practice of a psychologist, medical staff status shall
9 include and provide for the right to pursue and practice full clinical
10 privileges for holders of a doctoral degree of psychology within
11 the scope of their respective licensure. These rights and privileges
12 shall be limited or restricted only upon the basis of an individual
13 practitioner's demonstrated competence. Competence shall be
14 determined by health facility rules and medical staff bylaws that
15 are necessary and are applied in good faith, equally and in a
16 nondiscriminatory manner, to all practitioners, regardless of
17 whether they hold an M.D., D.O., D.D.S., D.P.M., or doctoral
18 degree in psychology.

19 (3) Nothing in this subdivision shall be construed to require a
20 health facility owned and operated by the state to offer a specific
21 health service or services not otherwise offered. If a health service
22 is offered in such a health facility that includes provisions for
23 medical staff membership and clinical privileges for clinical
24 psychologists, the facility shall not discriminate between persons
25 holding an M.D., D.O., D.D.S., D.P.M., or doctoral degree in
26 psychology who are authorized by law to perform the service
27 within the scope of the person's respective licensure.

28 (4) The rules and medical staff bylaws of a health facility
29 owned and operated by the state that include provisions for
30 medical staff membership and clinical privileges for; medical staff
31 and duly licensed clinical psychologists shall not discriminate on
32 the basis of whether the staff member holds an M.D., D.O., D.D.S.,
33 D.P.M., or doctoral degree in psychology within the scope of the
34 member's respective licensure. The health facility staff of these
35 health facilities who process, review, evaluate, and determine
36 qualifications for staff privileges for medical staff shall include, if
37 possible, staff members who are clinical psychologists.

38 (b) (1) The rules of a health facility not owned or operated by
39 this state may enable the appointment of clinical psychologists on
40 the terms and conditions that the facility shall establish. In these

health facilities, clinical psychologists may hold membership and serve on committees of the medical staff and carry professional responsibilities consistent with the scope of their licensure and their competence, subject to the rules of the health facility.

(2) Nothing in this subdivision shall be construed to require a health facility not owned or operated by this state to offer a specific health service or services not otherwise offered. If a health service is offered by a health facility with both licensed physicians and surgeons and clinical psychologists on the medical staff, which both licensed physicians and surgeons and clinical psychologists are authorized by law to perform, the service may be performed by either, without discrimination.

(3) This subdivision shall not prohibit a health facility that is a clinical teaching facility owned or operated by a university operating a school of medicine from requiring that a clinical psychologist have a faculty teaching appointment as a condition for eligibility for staff privileges at that facility.

(4) In any health facility that is not owned or operated by this state that provides staff privileges to clinical psychologists, the health facility staff who process, review, evaluate, and determine qualifications for staff privileges for medical staff shall include, if possible, staff members who are clinical psychologists.

(c) No classification of health facilities by the ~~state~~ department, nor any other classification of health facilities based on quality of service or otherwise, by any person, body, or governmental agency of this state or any subdivision thereof shall be affected by a health facility's provision for use of its facilities by duly licensed clinical psychologists, nor shall any ~~such~~ classification *of these facilities* be affected by the subjection of the psychologists to the rules and regulations of the organized professional staff. No classification of health facilities by any governmental agency of this state or any subdivision thereof pursuant to any law, whether enacted prior or subsequent to the effective date of this section, for the purposes of ascertaining eligibility for compensation, reimbursement, or other benefit for treatment of patients shall be affected by a health facility's provision for use of its facilities by duly licensed clinical psychologists, nor shall any ~~such~~ classification *of these facilities* be affected by the subjection of the psychologists to the rules and regulations of the organized professional staff which govern the psychologists' use of the facilities.

(d) “Clinical psychologist,” as used in this section, means a psychologist licensed by this state who meets both of the following requirements:

(1) Possesses an earned doctorate degree in psychology from an educational institution meeting the criteria of subdivision (b) of Section 2914 of the Business and Professions Code.

(2) Has not less than two years clinical experience in a multidisciplinary facility licensed or operated by this or another state or by the United States to provide health care, or, is listed in the latest edition of the National Register of Health Service Providers in Psychology, as adopted by the Council for the National Register of Health Service Providers in Psychology.

(e) Nothing in this section is intended to expand the scope of licensure of clinical psychologists. Notwithstanding the Ralph C. Dills Act (Chapter 10.3 (commencing with Section 3512) of Division 4 of Title 1 of the Government Code), the Public Employment Relations Board is precluded from creating any additional bargaining units for the purpose of exclusive representation of state psychologist employees that might result because of medical staff membership and/or privilege changes for psychologists due to the enactment of provisions by Assembly Bill No. 3141 of the 1995–96 Regular Session.

(f) The State Department of Mental Health, the State Department of Developmental Services, and the Department of Corrections shall report to the Legislature no later than January 1, 2006, on the impact of medical staff membership and privileges for clinical psychologists on quality of care, and on cost-effectiveness issues.

~~(g) This section shall remain in effect only until January 1, 2007, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2007, deletes or extends that date.~~

SEC. 4.6. Section 1316.5 of the Health and Safety Code, as amended by Section 2 of Chapter 717 of the Statutes of 1998, is repealed.

~~1316.5. (a) The rules of a health facility may enable the appointment of clinical psychologists on such terms and conditions as the facility shall establish. In such health facilities, clinical psychologists may hold membership and serve on committees of the medical staff and carry professional~~

1 ~~responsibilities consistent with the scope of their licensure and~~
2 ~~their competence, subject to the rules of the health facility.~~

3 ~~Nothing in this section shall be construed to require a health~~
4 ~~facility to offer a specific health service or services not otherwise~~
5 ~~offered. If a health service is offered by a health facility with both~~
6 ~~licensed physicians and surgeons and clinical psychologists on the~~
7 ~~medical staff, which both licensed physicians and surgeons and~~
8 ~~clinical psychologists are authorized by law to perform, such~~
9 ~~service may be performed by either, without discrimination.~~

10 ~~This subdivision shall not prohibit a health facility which is a~~
11 ~~clinical teaching facility owned or operated by a university~~
12 ~~operating a school of medicine from requiring that a clinical~~
13 ~~psychologist have a faculty teaching appointment as a condition~~
14 ~~for eligibility for staff privileges at that facility.~~

15 ~~In any health facility providing staff privileges to clinical~~
16 ~~psychologists, the health facility staff processing, reviewing,~~
17 ~~evaluating, and determining qualifications for staff privileges for~~
18 ~~medical staff shall include, if possible, staff members who are~~
19 ~~clinical psychologists.~~

20 ~~(b) No classification of health facilities by the state department,~~
21 ~~nor any other classification of health facilities based on quality of~~
22 ~~service or otherwise, by any person, body, or governmental agency~~
23 ~~of this state or any subdivision thereof shall be affected by a health~~
24 ~~facility's provision for use of its facilities by duly licensed clinical~~
25 ~~psychologists, nor shall any such classification be affected by the~~
26 ~~subjection of the psychologists to the rules and regulations of the~~
27 ~~organized professional staff. No classification of health facilities~~
28 ~~by any governmental agency of this state or any subdivision~~
29 ~~thereof pursuant to any law, whether enacted prior or subsequent~~
30 ~~to the effective date of this section, for the purposes of ascertaining~~
31 ~~eligibility for compensation, reimbursement, or other benefit for~~
32 ~~treatment of patients shall be affected by a health facility's~~
33 ~~provision for use of its facilities by duly licensed clinical~~
34 ~~psychologists, nor shall any such classification be affected by the~~
35 ~~subjection of the psychologists to the rules and regulations of the~~
36 ~~organized professional staff which govern the psychologists' use~~
37 ~~of the facilities.~~

38 ~~(c) "Clinical psychologist," as used in this section, means a~~
39 ~~psychologist licensed by this state and (1) who possesses an earned~~
40 ~~doctorate degree in psychology from an educational institution~~

~~meeting the criteria of subdivision (b) of Section 2914 of the Business and Professions Code and (2) has not less than two years clinical experience in a multidisciplinary facility licensed or operated by this or another state or by the United States to provide health care, or, is listed in the latest edition of the National Register of Health Service Providers in Psychology, as adopted by the Council for the National Register of Health Service Providers in Psychology.~~

~~(d) This section shall become operative on January 1, 2007.~~

SEC. 5. Article 7.5 (commencing with Section 1324) is added to Chapter 2 of Division 2 of the Health and Safety Code, to read:

Article 7.5. Intermediate Care Facilities' Quality Assurance Fees

1324. For purposes of this article, the following definitions shall apply:

(a) (1) "Gross receipts" means gross receipts paid as compensation for services provided to residents of a designated intermediate care facility.

(2) "Gross receipts" does not mean charitable contributions.

(3) For state and local government owned facilities, "gross receipts" shall include any contributions from government sources or General Fund expenditures for the care of residents of a designated intermediate care facility.

(b) "Eligible facility" means a designated intermediate care facility that has paid the fee as described in Section 1324.2, for a particular state fiscal year.

(c) "Designated intermediate care facility" or "facility" means a facility as defined in subdivision (e), (g), or (h) of Section 1250.

1324.2. (a) As a condition for participation in the Medi-Cal program, there shall be imposed each state fiscal year upon the entire gross receipts of a designated intermediate care facility a quality assurance fee, as calculated in accordance with subdivision (b).

(b) The quality assurance fee to be paid pursuant to subdivision (c) of Section 1324.4 shall be an amount determined each quarter of the state fiscal year by multiplying the facility's gross receipts in the preceding quarter by 6 percent. For reporting purposes, the

1 *quality assurance fee is considered to be on a cash basis of*
2 *accounting.*

3 *1324.4. (a) On or before August 31 of each year, each*
4 *designated intermediate care facility subject to Section 1324.2*
5 *shall report to the department, in a prescribed form, the facility's*
6 *gross receipts for the preceding state fiscal year.*

7 *(b) On or before the last day of each calendar quarter, each*
8 *designated intermediate care facility shall file a report with the*
9 *department, in a prescribed form, showing the facility's gross*
10 *receipts for the preceding quarter.*

11 *(c) A newly licensed care facility, as defined by the department,*
12 *shall be exempt from the requirements of subdivision (a) for its year*
13 *of operation, but shall complete all requirements of subdivision (b)*
14 *for any portion of the quarter in which it commences operations.*

15 *(d) The quality assurance fee, as calculated pursuant to*
16 *subdivision (b) of Section 1324.2, shall be paid to the department*
17 *on or before the last day of the quarter following the quarter for*
18 *which the fee is imposed.*

19 *(e) The payment of the quality assurance fee a designated*
20 *intermediate care facility shall be reported as an allowable cost for*
21 *Medi-Cal reimbursement purposes.*

22 *(f) The department shall make retrospective adjustments, as*
23 *necessary, to the amounts calculated pursuant to subdivision (b)*
24 *of Section 1324.2 in order to assure that the facility's aggregate*
25 *quality assurance fee for any particular state fiscal year does not*
26 *exceed 6 percent of the facility's aggregate annual gross receipts*
27 *for that year.*

28 *1324.6. (a) The Director of Health Services, or his or her*
29 *designee, shall administer this article.*

30 *(b) The director may adopt regulations as are necessary to*
31 *implement this article. These regulations may be adopted as*
32 *emergency regulations in accordance with the rulemaking*
33 *provisions of the Administrative Procedure Act (Chapter 3.5*
34 *(commencing with Section 11340) of Part 1 of Division 3 of Title*
35 *2 of the Government Code). For purposes of this article, the*
36 *adoption of regulations shall be deemed an emergency and*
37 *necessary for the immediate preservation of the public peace,*
38 *health and safety, or general welfare. The regulations shall*
39 *include, but not be limited to, any regulations necessary for either*
40 *of the following purposes:*

1 *(1) The administration of this article, including the proper*
2 *imposition and collection of the quality assurance fee.*

3 *(2) The development of any forms necessary to obtain required*
4 *information from facilities subject to the quality assurance fee.*

5 *(c) As an alternative to subdivision (b), and notwithstanding*
6 *Chapter 3.5 (commencing with Section 11340) of Part 1 of*
7 *Division 3 of Title 2 of the Government Code, the director may*
8 *implement this article by means of a provider bulletin, or other*
9 *similar instructions, without taking regulatory action.*

10 *1324.8. The quality assurance fee assessed and collected*
11 *pursuant to this article shall be deposited in the General Fund.*

12 *1324.10. In addition to the rate of payment that an eligible*
13 *facility would otherwise receive for intermediate care facility*
14 *services provided to Medi-Cal beneficiaries, an eligible facility*
15 *shall receive quarterly supplemental Medi-Cal reimbursement, in*
16 *an amount determined by the department.*

17 *The supplemental Medi-Cal reimbursement provided by this*
18 *section shall be paid to support the facility's quality improvement*
19 *efforts and shall be distributed under a payment methodology*
20 *based on intermediate care services provided to Medi-Cal patients*
21 *at the eligible facility, either on a per diem basis, or on any other*
22 *federally permissible basis.*

23 *1324.12. (a) (1) The department shall seek approval from*
24 *the federal Centers for Medicare and Medicaid Services for the*
25 *implementation of this article.*

26 *(2) If after seeking federal approval, federal approval is not*
27 *obtained, this article shall not be implemented.*

28 *(3) The Director of Health Services may alter the methodology*
29 *specified in this article to the extent necessary to meet the*
30 *requirements of federal law or regulations, or to obtain federal*
31 *approval.*

32 *(b) If there is a final judicial determination by any court of*
33 *appellate jurisdiction or a final determination by the*
34 *Administrator of the federal Center for Medicare and Medicaid*
35 *Services that the supplemental reimbursement provided by this*
36 *article shall be made to any facility not described in this article,*
37 *this article shall immediately become inoperative.*

38 *1324.14. In implementing this article, the department may*
39 *utilize the services of the Medi-Cal fiscal intermediary through a*
40 *change order to the fiscal intermediary contract to administer this*

1 *program, consistent with the requirements of Sections 14104.6,*
2 *14104.7, 14104.8, and 14104.9 of the Welfare and Institutions*
3 *Code.*

4 *SEC. 6. Section 104181.6 is added to the Health and Safety*
5 *Code, to read:*

6 *104181.6. Notwithstanding subdivision (a) of Section 2.00 of*
7 *the Budget Act of 2002 and any other provision of law,*
8 *commencing with the appropriation for the 2002–03 fiscal year,*
9 *and for each fiscal year thereafter, any amount appropriated to the*
10 *department for the Cancer Research Program shall be available,*
11 *for purposes of that program, for encumbrance for one fiscal year*
12 *beyond the year of appropriation and for expenditure for three*
13 *fiscal years beyond the year of encumbrance.*

14 *SEC. 7. Section 104465 of the Health and Safety Code is*
15 *amended to read:*

16 *104465. (a) The department shall may annually set aside*
17 *three million dollars (\$3,000,000) appropriated for the purposes of*
18 *the competitive grants program established pursuant to this article*
19 *in order to support efforts to link the statewide media campaign to*
20 *local communities and to provide regional public and community*
21 *relations or media initiatives.*

22 *(b) Local community initiatives may include, but are not*
23 *limited to, all of the following:*

24 *(1) Encouraging volunteer efforts.*

25 *(2) Local media programming.*

26 *(3) Provision of assistance in, and facilitation of, public and*
27 *community events.*

28 *(c) The efforts described in subdivision (b) shall be directed*
29 *principally to the target communities described in Section 24161.5*
30 *104360.*

31 *(d) Regular application procedures for competitive grants*
32 *under this article shall apply to applications for grants under this*
33 *section.*

34 *(e) Funds awarded pursuant to this section shall be awarded in*
35 *the same manner as other competitive grants under this article.*

36 *SEC. 8. Section 104466 is added to the Health and Safety*
37 *Code, to read:*

38 *104466. Notwithstanding subdivision (a) of Section 2.00 of*
39 *the Budget Act of 2002 and any other provision of law,*
40 *commencing with the appropriation for the 2002–03 fiscal year,*

1 and for each fiscal year thereafter, any amount appropriated to the
2 department to implement the following tobacco use prevention
3 programs shall be available for encumbrance and expenditure for
4 three fiscal years beyond the date of the appropriation:

5 (a) The program to evaluate tobacco control programs
6 provided for in subdivisions (b) and (c) of Section 104375.

7 (b) The tobacco use prevention media campaign provided for
8 in subdivision (e) of Section 104375.

9 (c) The competitive grant program provided for in Section
10 104385.

11 (d) The local lead agency tobacco use prevention programs
12 provided for in Section 104400.

13 (e) The tobacco use prevention program directed at schools
14 provided for in Sections 104420, 104425, 104430, and 104435.

15 SEC. 9. Section 104898.5 of the Health and Safety Code is
16 amended to read:

17 104898.5. (a) Notwithstanding any other provision of law,
18 there shall be transferred annually from the General Fund to the
19 Tobacco Settlement Fund an amount, not to exceed ~~two hundred~~
20 ~~fifty one hundred~~ million dollars ~~(\$250,000,000)~~ (\$100,000,000)
21 out of funds not otherwise appropriated, as a loan to cover
22 appropriations from the fund when moneys from the Master
23 Settlement Agreement have not been received by the state.

24 (b) This loan from the General Fund shall be repaid on or
25 before June 30 of each year, without interest, from the funds
26 received pursuant to the Master Settlement Agreement.

27 SEC. 10. Section 120955 of the Health and Safety Code is
28 amended to read:

29 120955. (a) (1) To the extent that state and federal funds are
30 appropriated in the annual Budget Act for these purposes, the
31 director shall establish and may administer a program to provide
32 drug treatments to persons infected with human
33 immunodeficiency virus (HIV), the etiologic agent of acquired
34 immune deficiency syndrome (AIDS). ~~The~~ If the director makes
35 a formal determination that, in any fiscal year, funds appropriated
36 for the program will be insufficient to provide all of those drug
37 treatments to existing eligible persons for the fiscal year and that
38 a suspension of the implementation of the program is necessary,
39 the director may suspend eligibility determinations and enrollment

1 *in the program for the period of time necessary to meet the needs*
2 *of existing eligible persons in the program.*

3 (2) The director shall develop, maintain, and update as
4 necessary a list of drugs to be provided under this program. ~~Drugs~~
5 ~~on the list shall include, but not be limited to, the drugs zidovudine~~
6 ~~(AZT) and aerosolized pentamidine.~~

7 (b) The director may grant funds to a county public health
8 department through standard agreements to administer this
9 program in that county. To maximize the recipients' access to
10 drugs covered by this program, the director shall urge the county
11 health department in counties granted these funds to decentralize
12 distribution of the drugs to the recipients.

13 (c) The director shall establish a rate structure for
14 reimbursement for the cost of each drug included in the program.
15 Rates shall not be less than the actual cost of the drug. However,
16 the director may purchase a listed drug directly from the
17 manufacturer and negotiate the most favorable bulk price for that
18 drug.

19 (d) Manufacturers of the drugs on the list shall pay the
20 department a rebate equal to the rebate that would be applicable to
21 the drug under Section 1927(c) of the federal Social Security Act
22 (42 U.S.C. Sec. 1396r-8(c)) plus an additional rebate to be
23 negotiated by each manufacturer with the department, except that
24 no rebates shall be paid to the department under this section on
25 drugs for which the department has received a rebate under Section
26 1927(c) of the federal Social Security Act (42 U.S.C. Sec.
27 1396r-8(c)) or that have been purchased on behalf of county health
28 departments or other eligible entities at discount prices made
29 available under Section 256b of Title 42 of the United States Code.

30 (e) The department shall submit an invoice, not less than two
31 times per year, to each manufacturer for the amount of the rebate
32 required by subdivision (d).

33 (f) Drugs may be removed from the list for failure to pay the
34 rebate required by subdivision (d), unless the department
35 determines that removal of the drug from the list would cause
36 substantial medical hardship to beneficiaries.

37 (g) The department may adopt emergency regulations to
38 implement amendments to this chapter made during the 1997–98
39 Regular Session, in accordance with the Administrative Procedure
40 Act, Chapter 3.5 (commencing with Section 11340) of Part 1 of

1 Division 3 of Title 2 of the Government Code. The initial adoption
2 of emergency regulations shall be deemed to be an emergency and
3 considered by the Office of Administrative Law as necessary for
4 the immediate preservation of the public peace, health and safety,
5 or general welfare. Emergency regulations adopted pursuant to
6 this section shall remain in effect for no more than 180 days.

7 (h) Reimbursement under this chapter shall not be made for any
8 drugs that are available to the recipient under any other private,
9 state, or federal programs, or under any other contractual or legal
10 entitlements, except that the director may authorize an exemption
11 from this subdivision where exemption would represent a cost
12 savings to the state.

13 *SEC. 11. Chapter 16 (commencing with Section 121345) is*
14 *added to Part 4 of Division 105 of the Health and Safety Code, to*
15 *read:*

16
17 *CHAPTER 16. THERAPEUTIC MONITORING PROGRAM*
18

19 *121345. (a) The Legislature finds and declares that*
20 *therapeutic monitoring is necessary to make appropriate*
21 *life-prolonging and cost-effective treatment decisions in the*
22 *management of HIV disease.*

23 *(b) The Director of the Office of AIDS may provide funding for*
24 *the coverage of therapeutic monitoring assays for HIV disease*
25 *through the State HIV Therapeutic Monitoring Program.*

26 *(c) (1) The purpose of the program under this chapter shall be*
27 *to provide the therapeutic assays for HIV-positive people who*
28 *could not otherwise afford them.*

29 *(2) The scope of the program shall be determined by the federal*
30 *and state guidelines for standards of HIV care and availability of*
31 *funding.*

32 *(3) Priority for funding under the State HIV Therapeutic*
33 *Monitoring Program shall be given to the state-funded Early*
34 *Intervention Program sites.*

35 *(d) Therapeutic monitoring under this chapter shall include,*
36 *but not be limited to, viral load and resistance assays.*

37 *(e) Coverage awards shall be made to counties on the basis of*
38 *need. The determination of awards shall be made by the Office of*
39 *AIDS, depending on the availability of state and federal funding*
40 *for the program. Counties may cover those assays that are*

1 *determined to be necessary and are not covered under the state*
2 *program.*

3 *SEC. 12. Section 123853 is added to the Health and Safety*
4 *Code, to read:*

5 *123853. (a) The department may enter into contracts with*
6 *one or more manufacturers on a negotiated or bid basis as the*
7 *purchaser, but not the dispenser or distributor, of factor*
8 *replacement therapies under the California Children's Services*
9 *Program for the purpose of enabling the department to obtain the*
10 *full range of available therapies and services required for clients*
11 *with hematological disorders at the most favorable price and to*
12 *enable the department, notwithstanding any other provision of*
13 *state law, to obtain discounts, rebates, or refunds from the*
14 *manufacturers based upon the large quantities purchased under*
15 *the program. Nothing in this subdivision shall interfere with the*
16 *usual and customary distribution practices of factor replacement*
17 *therapies. In order to achieve maximum cost savings, the*
18 *Legislature hereby determines that an expedited contract process*
19 *under this section is necessary. Therefore, a contract under this*
20 *subdivision may be on a negotiated basis and shall be exempt from*
21 *Chapter 2 (commencing with Section 10290) of Part 2 of Division*
22 *2 of the Public Contract Code and Chapter 6 (commencing with*
23 *Section 14825) of Part 5.5 of Division 3 of the Government Code.*

24 *(b) The department may enter into contracts on a bid or*
25 *negotiated basis with manufacturers, distributors, dispensers, or*
26 *suppliers of pharmaceuticals, appliances, durable medical*
27 *equipment, medical supplies, and other product-type health care*
28 *services and laboratories for the purpose of obtaining the most*
29 *favorable prices to the state and to assure adequate access and*
30 *quality of the product or service. In order to achieve maximum cost*
31 *savings, the Legislature hereby determines that an expedited*
32 *contract process under this subdivision is necessary. Therefore,*
33 *contracts under this subdivision may be on a negotiated basis and*
34 *shall be exempt from the provisions of Chapter 2 (commencing*
35 *with Section 10290) of Part 2 of Division 2 of the Public Contract*
36 *Code and Chapter 6 (commencing with Section 14825), Part 5.5,*
37 *Division 3 of the Government Code. This subdivision shall not*
38 *apply to pharmacies or suppliers that provide blood, blood*
39 *derivatives, or blood factor products, or any product or service*
40 *provided by those pharmacies or suppliers.*

1 (c) The department may contract with one or more
2 manufacturers of each multisource prescribed product or supplier
3 of outpatient clinical laboratory services on a bid or negotiated
4 basis. Contracts for outpatient clinical laboratory services shall
5 require that the contractor be a clinical laboratory licensed or
6 certified by the State of California or certified under Section 263a
7 of Title 42 of the United States Code. Nothing in this subdivision
8 shall be construed as prohibiting the department from contracting
9 with less than all manufacturers or clinical laboratories, including
10 just one manufacturer or clinical laboratory, on a bid or
11 negotiated basis.

12 SEC. 13. Section 124555 of the Health and Safety Code is
13 amended to read:

14 124555. (a) (1) It is the intent of the Legislature that funds
15 distributed under this section promote stability for participating
16 clinics, as a part of the state's health care safety net, and at the same
17 time be distributed in a manner that best promotes access to health
18 care to seasonal agricultural and migratory workers and their
19 families.

20 (2) The department shall grant funds, for ~~up to~~ a minimum of
21 three years per grant, retroactive to funds appropriated in the
22 Budget Act of 2002 (Chapter 379 of the Statutes of 2002), to
23 eligible, private, nonprofit, community-based primary care clinics
24 for the purpose of establishing and maintaining a health services
25 program for seasonal agricultural and migratory workers and their
26 families.

27 (b) In order to be eligible to receive funds under this program,
28 a clinic shall, at a minimum, meet all of the following conditions:

29 (1) The clinic shall be licensed under either paragraph (1) or (2)
30 of subdivision (a) of Section 1204.

31 (2) The clinic's patient population shall include at least 25
32 percent farmworkers and their dependents.

33 (3) The clinic shall operate in a medically underserved area,
34 including a Health Professional Shortage Area, or serve a
35 medically underserved population, as designated by the United
36 States Department of Health and Human Services, or shall be able
37 to demonstrate that at least 50 percent of its patients are persons
38 with incomes at or below 200 percent of the federal poverty level.

1 (c) The department shall seek input from stakeholders in
2 designing the methodology for distribution of funds under this
3 section.

4 *SEC. 14. Section 124710 of the Health and Safety Code is*
5 *amended to read:*

6 124710. (a) (1) It is the intent of the Legislature that funds
7 distributed under this section promote stability for participating
8 clinics, as a part of the state's health care safety net, and at the same
9 time be distributed in a manner that best promotes access to health
10 care to geographically isolated populations.

11 (2) The department shall grant funds, for ~~up to a minimum of~~
12 three years per grant, *retroactive to funds appropriated in the*
13 *Budget Act of 2002 (Chapter 379 of the Statutes of 2002)*, to
14 eligible, private, nonprofit, community-based primary care clinics
15 for the purpose of establishing and maintaining rural health
16 services and development projects as specified under this article.

17 (b) In order to be eligible to receive funds under this program,
18 a clinic shall, at a minimum, meet all of the following conditions:

19 (1) The clinic shall be licensed under paragraph (1) or (2) of
20 subdivision (a) of Section 1204.

21 (2) The clinic shall operate in a "rural" Medical Study Service
22 Area, as defined by the Health Manpower Commission.

23 (3) The clinic shall operate in a medically underserved area,
24 including a Health Professional Shortage Area, or serve a
25 medically underserved population, as designated by the United
26 States Department of Health and Human Services, or shall be able
27 to demonstrate that at least 50 percent of its patients are persons
28 with incomes at or below 200 percent of the federal poverty level.

29 (c) The department shall seek input from stakeholders in
30 designing the methodology for distribution of funds under this
31 section.

32 (d) If the funds that are available for purposes of this section for
33 any fiscal year are greater than funds that were available for the
34 prior fiscal year, the department shall establish a base funding level
35 that is applicable to all sites funded in the prior fiscal year. To the
36 extent that funds are available, the base funding level shall not be
37 less than seventy-five thousand dollars (\$75,000) for each site. To
38 implement this section, the department shall not be required to
39 reduce funding for clinics that are above the minimum awards.

1 *SEC. 15. Section 125191 is added to the Health and Safety*
2 *Code, to read:*

3 125191. (a) *The department may enter into contracts with*
4 *one or more manufacturers on a negotiated or bid basis as the*
5 *purchaser, but not the dispenser or distributor, of factor*
6 *replacement therapies under the genetically handicapped persons*
7 *program for the purpose of enabling the department to obtain the*
8 *full range of available therapies and services required for clients*
9 *with hematological disorders at the most favorable price and to*
10 *enable the department, notwithstanding any other provision of*
11 *state law, to obtain discounts, rebates, or refunds from the*
12 *manufacturers based upon the large quantities purchased under*
13 *the program. Nothing in this subdivision shall interfere with the*
14 *usual and customary distribution practices of factor replacement*
15 *therapies. In order to achieve maximum cost savings, the*
16 *Legislature hereby determines that an expedited contract process*
17 *under this section is necessary. Therefore, a contract under this*
18 *subdivision may be on a negotiated basis and shall be exempt from*
19 *Chapter 2 (commencing with Section 10290) of Part 2 of Division*
20 *2 of the Public Contract Code and Chapter 6 (commencing with*
21 *Section 14825) of Part 5.5 of Division 3 of the Government Code.*

22 (b) *The department may enter into contracts on a bid or*
23 *negotiated basis with manufacturers, distributors, dispensers, or*
24 *suppliers of pharmaceuticals, appliances, durable medical*
25 *equipment, medical supplies, and other product-type health care*
26 *services and laboratories for the purpose of obtaining the most*
27 *favorable prices to the state and to assure adequate access and*
28 *quality of the product or service. In order to achieve maximum cost*
29 *savings, the Legislature hereby determines that an expedited*
30 *contract process under this subdivision is necessary. Therefore,*
31 *contracts under this subdivision may be on a negotiated basis and*
32 *shall be exempt from the provisions of Chapter 2 (commencing*
33 *with Section 10290) of Part 2 of Division 2 of the Public Contract*
34 *Code and Chapter 6 (commencing with Section 14825), Part 5.5,*
35 *Division 3 of the Government Code. This subdivision shall not*
36 *apply to pharmacies or suppliers that provide blood, blood*
37 *derivatives, or blood factor products, or any product or service*
38 *provided by those pharmacies or suppliers.*

39 (c) *The department may contract with one or more*
40 *manufacturers of each multisource prescribed product or supplier*

1 of outpatient clinical laboratory services on a bid or negotiated
2 basis. Contracts for outpatient clinical laboratory services shall
3 require that the contractor be a clinical laboratory licensed or
4 certified by the State of California or certified under Section 263a
5 of Title 42 of the United States Code. Nothing in this subdivision
6 shall be construed as prohibiting the department from contracting
7 with less than all manufacturers or clinical laboratories, including
8 just one manufacturer or clinical laboratory, on a bid or
9 negotiated basis.

10 SEC. 16. Section 127280.1 of the Health and Safety Code is
11 amended to read:

12 127280.1. Notwithstanding any other provision of law, up to
13 two hundred thousand dollars (\$200,000) of the moneys collected
14 pursuant to Section 127280 may be used ~~in the 2002-03 fiscal year~~
15 by the State Department of Health Services for data collection on,
16 analysis of, and reporting on, maternal and perinatal outcomes, if
17 funds are appropriated in the Budget Act.

18 SEC. 17. Section 12693.43 of the Insurance Code is amended
19 to read:

20 12693.43. (a) Applicants applying to the purchasing pool
21 shall agree to pay family contributions, unless the applicant has a
22 family contribution sponsor. Family contribution amounts consist
23 of the following two components:

24 (1) The flat fees described in subdivision (b) or (d).

25 (2) Any amounts that are charged to the program by
26 participating health, dental, and vision plans selected by the
27 applicant that exceed the cost to the program of the highest cost
28 Family Value Package in a given geographic area.

29 (b) In each geographic area, the board shall designate one or
30 more Family Value Packages for which the required total family
31 contribution is:

32 (1) Seven dollars (\$7) per child with a maximum required
33 contribution of fourteen dollars (\$14) per month per family for
34 applicants with annual household incomes up to and including 150
35 percent of the federal poverty level.

36 (2) Nine dollars (\$9) per child with a maximum required
37 contribution of twenty-seven dollars (\$27) per month per family
38 for applicants with annual household incomes greater than 150
39 percent and up to and including 200 percent of the federal poverty
40 level and for applicants on behalf of children described in clause

1 *(ii) of subparagraph (A) of paragraph (6) of subdivision (a) of*
2 *Section 12693.70.*

3 (c) Combinations of health, dental, and vision plans that are
4 more expensive to the program than the highest cost Family Value
5 Package may be offered to and selected by applicants. However,
6 the cost to the program of those combinations that exceeds the
7 price to the program of the highest cost Family Value Package shall
8 be paid by the applicant as part of the family contribution.

9 (d) The board shall provide a family contribution discount to
10 those applicants who select the health plan in a geographic area
11 that has been designated as the Community Provider Plan. The
12 discount shall reduce the portion of the family contribution
13 described in subdivision (b) to the following:

14 (1) A family contribution of four dollars (\$4) per child with a
15 maximum required contribution of eight dollars (\$8) per month
16 per family for applicants with annual household incomes up to and
17 including 150 percent of the federal poverty level.

18 (2) Six dollars (\$6) per child with a maximum required
19 contribution of eighteen dollars (\$18) per month per family for
20 applicants with annual household incomes greater than 150
21 percent and up to and including 200 percent of the federal poverty
22 level *and for applicants on behalf of children described in clause*
23 *(ii) of subparagraph (A) of paragraph (6) of subdivision (a) of*
24 *Section 12693.70.*

25 (e) Applicants, but not family contribution sponsors, who pay
26 three months of required family contributions in advance shall
27 receive the fourth consecutive month of coverage with no family
28 contribution required.

29 (f) Applicants, but not family contribution sponsors, who pay
30 the required family contributions by an approved means of
31 electronic fund transfer shall receive a 25-percent discount from
32 the required family contributions.

33 (g) It is the intent of the Legislature that the family contribution
34 amounts described in this section comply with the premium cost
35 sharing limits contained in Section 2103 of Title XXI of the Social
36 Security Act. If the amounts described in subdivision (a) are not
37 approved by the federal government, the board may adjust these
38 amounts to the extent required to achieve approval of the state
39 plan.



SEC. 18. Section 12693.70 of the Insurance Code is amended to read:

12693.70. To be eligible to participate in the program, an applicant shall meet all of the following requirements:

(a) Be an applicant applying on behalf of an eligible child, which means a child who is all of the following:

(1) Less than 19 years of age. An application may be made on behalf of a child not yet born up to three months prior to the expected date of delivery. Coverage shall begin as soon as administratively feasible, as determined by the board, after the board receives notification of the birth. However, no child less than 12 months of age shall be eligible for coverage until 90 days after the enactment of the Budget Act of 1999.

(2) Not eligible for no-cost full-scope Medi-Cal or Medicare coverage at the time of application.

(3) In compliance with Sections 12693.71 and 12693.72.

(4) A child who meets citizenship and immigration status requirements that are applicable to persons participating in the program established by Title XXI of the Social Security Act, except as specified in Section 12693.76.

(5) A resident of the State of California pursuant to Section 244 of the Government Code; or, if not a resident pursuant to Section 244 of the Government Code, is physically present in California and entered the state with a job commitment or to seek employment, whether or not employed at the time of application to or after acceptance in, the program.

(6) (A) ~~In~~ In either of the following:

(i) In a family with an annual or monthly household income equal to or less than 200 percent of the federal poverty level.

(ii) When implemented by the board, subject to subdivision (b) of Section 12693.765 and pursuant to this section, a child under the age of two years who was delivered by a mother enrolled in the Access for Infants and Mothers Program as described in Part 6.3 (commencing with Section 12695). For purposes of this clause, any infant born to a woman whose enrollment in the Access for Infants and Mothers Program begins after June 30, 2004, shall be automatically enrolled in the Healthy Families Program. This enrollment shall cover the first 12 months of the infant's life. At the end of the 12 months, as a condition of continued eligibility, the applicant shall provide income information. The infant shall be

1 *disenrolled if the gross annual household income exceeds the*
2 *income eligibility standard that was in effect in the Access for*
3 *Infants and Mothers Program at the time the infant's mother*
4 *became eligible, or following the two-month period established in*
5 *Section 12693.981 if the infant is eligible for Medi-Cal with no*
6 *share of cost. At the end of the second year, infants shall again be*
7 *screened for program eligibility pursuant to this section, with*
8 *income eligibility evaluated pursuant to clause (i), subparagraphs*
9 *(B) and (C), and paragraph (2) of subdivision (a).*

10 (B) All income over 200 percent of the federal poverty level but
11 less than or equal to 250 percent of the federal poverty level shall
12 be disregarded in calculating annual or monthly household
13 income.

14 (C) In a family with an annual or monthly household income
15 greater than 250 percent of the federal poverty level, any income
16 deduction that is applicable to a child under Medi-Cal shall be
17 applied in determining the annual or monthly household income.
18 If the income deductions reduce the annual or monthly household
19 income to 250 percent or less of the federal poverty level,
20 subparagraph (B) shall be applied.

21 (b) If the applicant is applying for the purchasing pool, and
22 does not have a family contribution sponsor the applicant shall pay
23 the first month's family contribution and agree to remain in the
24 program for six months, unless other coverage is obtained and
25 proof of the coverage is provided to the program.

26 (c) An applicant shall enroll all of the applicant's eligible
27 children in the program.

28 (d) In filing documentation to meet program eligibility
29 requirements, if the applicant's income documentation cannot be
30 provided, as defined in regulations promulgated by the board, the
31 applicant's signed statement as to the value or amount of income
32 shall be deemed to constitute verification.

33 (e) An applicant shall pay in full any family contributions owed
34 in arrears for any health, dental, or vision coverage provided by the
35 program within the prior 12 months.

36 *SEC. 19. Section 12693.73 of the Insurance Code is amended*
37 *to read:*

38 12693.73. Notwithstanding any other provision of law,
39 children excluded from coverage under Title XXI of the Social
40 Security Act are not eligible for coverage under the program,

1 except as specified in *clause (ii) of subparagraph (A) of paragraph*
2 *(6) of subdivision (a) of Section 12693.70 and Section 12693.76.*

3 *SEC. 20. Section 12693.765 is added to the Insurance Code,*
4 *to read:*

5 *12693.765. (a) Notwithstanding any other provision of law*
6 *and subject to subdivision (b), a child described in clause (ii) of*
7 *subparagraph (A) of paragraph (6) of subdivision (a) of Section*
8 *12693.70 shall be deemed eligible to participate in the program at*
9 *birth.*

10 *(b) Notwithstanding any other provision of law, subdivision (a)*
11 *and clause (ii) of subparagraph (A) of paragraph (6) of*
12 *subdivision (a) of Section 12693.70 may only be implemented to*
13 *the extent that funds are appropriated for that purpose in the*
14 *annual Budget Act or other statute.*

15 *SEC. 21. Section 12693.91 of the Insurance Code is amended*
16 *to read:*

17 *12693.91. (a) The State Department of Health Services, in*
18 *conjunction with the Managed Risk Medical Insurance Board, the*
19 *County Medical Services Program board, and the Rural Health*
20 *Policy Council, may develop and administer up to five*
21 *demonstration projects in rural areas that are likely to contain a*
22 *significant level of uninsured children, including seasonal and*
23 *migratory worker dependents. In addition to any other funds*
24 *provided pursuant to this section the grants for demonstration*
25 *projects may include funds pursuant to subdivision (d).*

26 *(b) The purpose of the demonstration projects shall be to fund*
27 *rural collaborative health care networks to alleviate unique*
28 *problems of access to health care in rural areas.*

29 *(c) The State Department of Health Services, in conjunction*
30 *with the Managed Risk Medical Insurance Board and Rural Health*
31 *Policy Council, shall establish the criteria and standards for*
32 *eligibility to be used in requests for proposals or requests for*
33 *application, the application review process, determining the*
34 *maximum amount and number of grants to be awarded, preference*
35 *and priority of projects, and compliance monitoring after*
36 *receiving comment from the public.*

37 *(d) The grants may include funds for purchasing equipment,*
38 *making capital expenditures, and providing infrastructure,*
39 *including, but not limited to, salaries and payment of leaseholds.*
40 *The funds under this subdivision may only be awarded to qualified*

1 eligible health care entities as determined by the State Department
2 of Health Services. Title to any equipment or capital improvement
3 purchased or acquired with grant funds shall vest in the grantee for
4 the public good and not the state. Capital expenditures shall not
5 include the acquisition of land. Notwithstanding subdivision (e),
6 this subdivision shall be implemented only when funds are
7 appropriated in the annual Budget Act or another statute to fund
8 the cost of implementing this subdivision.

9 (e) This section shall only become operative upon federal
10 approval of the state plan or subsequent amendments for the
11 program and approval of federal financial participation.

12 ~~(f) This section shall become inoperative on July 1, 2003.~~

13 SEC. 22. *Section 12693.98 of the Insurance Code is amended*
14 *to read:*

15 12693.98. (a) (1) The Medi-Cal-to-Healthy Families
16 Bridge Benefits Program is hereby established to provide any child
17 who meets the criteria set forth in subdivision (b) with a ~~two~~ one
18 calendar-month period of health care benefits in order to provide
19 the child with an opportunity to apply for the Healthy Families
20 Program established under Chapter 16 (commencing with Section
21 12693).

22 (2) The Medi-Cal-to-Healthy Families Bridge Benefits
23 Program shall be administered by the board.

24 (b) (1) Any child who meets all of the following requirements
25 shall be eligible for ~~two~~ one calendar ~~months~~ month of Healthy
26 Families benefits funded by Title XXI of the Social Security Act,
27 known as the State Children's Health Insurance Program:

28 (A) He or she has been receiving, but is no longer eligible for,
29 full-scope Medi-Cal benefits without a share of cost.

30 (B) He or she is eligible for full-scope Medi-Cal benefits with
31 a share of cost.

32 (C) He or she is under 19 years of age at the time he or she is
33 no longer eligible for full-scope Medi-Cal benefits without a share
34 of cost.

35 (D) He or she has family income at or below 200 percent of the
36 federal poverty level.

37 (E) He or she is not otherwise excluded under the definition of
38 targeted low-income child under subsections (b)(1)(B)(ii),
39 (b)(1)(C), and (b)(2) of Section 2110 of the Social Security Act (42

1 U.S.C. Secs. 1397jj(b)(1)(B)(ii), 1397jj(b)(1)(C), and
2 1397jj(b)(2)).

3 (2) The ~~two one~~ calendar ~~months~~ *month* of benefits under this
4 chapter shall begin on the first day of the month following the last
5 day of the receipt of benefits without a share of cost.

6 (c) The income methodology for determining a child's family
7 income, as required by paragraph (1) of subdivision (b) shall be the
8 same methodology used in determining a child's eligibility for the
9 full scope of Medi-Cal benefits.

10 (d) The ~~two-calendar-month~~ *one calendar-month* period of
11 Healthy Families benefits provided under this chapter shall be
12 identical to the scope of benefits that the child was receiving under
13 the Medi-Cal program without a share of cost.

14 (e) The ~~two-calendar-month~~ *one calendar-month* period of
15 Healthy Families benefits provided under this chapter shall only
16 be made available through a Medi-Cal provider or under a
17 Medi-Cal managed care arrangement or contract.

18 (f) ~~Nothing~~ *Except as provided in subdivision (j), nothing* in
19 this section shall be construed to provide Healthy Families benefits
20 for more than a ~~two one~~ calendar-month period under any
21 circumstances, including the failure to apply for benefits under the
22 Healthy Families Program or the failure to be made aware of the
23 availability of the Healthy Families Program, unless the
24 circumstances described in subdivision (b) reoccur.

25 (g) (1) This section shall become operative on the first day of
26 the second month following the effective date of this section,
27 subject to paragraph (2).

28 (2) Under no circumstances shall this section become operative
29 until, and shall be implemented only to the extent that, all
30 necessary federal approvals, including approval of any
31 amendments to the State Child Health Plan have been sought and
32 obtained and federal financial participation under the federal State
33 Children's Health Insurance Program, as set forth in Title XXI of
34 the Social Security Act, has been approved.

35 (h) This section shall become inoperative if an unappealable
36 court decision or judgment determines that any of the following
37 apply:

38 (1) The provisions of this section are unconstitutional under the
39 United States Constitution or the California Constitution.

(2) The provisions of this section do not comply with the State Children's Health Insurance Program, as set forth in Title XXI of the Social Security Act.

(3) The provisions of this section require that the health care benefits provided pursuant to this section are required to be furnished for more than ~~two calendar months~~ *two calendar months*.

(i) If the State Child Health Insurance Program waiver described in Section 12693.755 is approved, and at the time the waiver is implemented, the benefits described in this section shall also be available to persons who meet the eligibility requirements of the program and are parents of, or, as defined by the board, adults responsible for, children enrolled to receive coverage under this part or enrolled to receive full scope Medi-Cal services with no share of cost.

(j) *The one month of benefits provided in this section shall be increased to two months commencing on implementation of the waiver referred to in Section 12693.755.*

SEC. 23. Section 12693.99 of the Insurance Code is repealed.
~~12693.99. This part shall remain in effect only until January 1, 2004, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2004, deletes or extends that date.~~

SEC. 24. Section 12695.04 of the Insurance Code is amended to read:

12695.04. "Advisory panel" means the ~~Major~~ *Managed Risk* Medical Insurance Board Access for Infants and Mothers Advisory Panel created pursuant to Section ~~12696.4~~ 12696.5.

SEC. 25. Section 12695.06 of the Insurance Code is amended to read:

12695.06. "Applicant" means an individual who applies for coverage ~~for perinatal and infant care~~ through the program.

SEC. 26. Section 12695.08 of the Insurance Code is amended to read:

12695.08. "Board" means the ~~Major~~ *Managed Risk* Medical Insurance Board created pursuant to Section 12710.

SEC. 27. Section 12696.7 of the Insurance Code is amended to read:

12696.7. (a) The board ~~shall~~ *may* contract with a variety of health plans and types of health care service delivery systems in

order to offer subscribers a choice of plans, providers, and types of service delivery.

(b) Participating health plans contracting with the board pursuant to this part shall provide benefits or coverage to subscribers only as determined by the board pursuant to subdivision (b) of Section 12696.05.

~~(c) Participating health plans shall not be required to comply with any other provisions of law or regulations relating to the provision of benefits under this part for subscribers enrolled in the program.~~

SEC. 28. Section 12697 of the Insurance Code is amended to read:

12697. The board ~~shall~~ may negotiate or arrange for stop-loss insurance coverage that limits the program's fiscal responsibility for the total costs of health services provided to program subscribers, or arrange for participating health plans to share or assume the financial risk for a portion of the total cost of health care services to program subscribers, or both.

SEC. 29. Section 12698.05 of the Insurance Code is amended to read:

12698.05. A person shall not be eligible to participate in the program if the person is ~~a~~ eligible for Medi-Cal without a share of cost or eligible for Medicare beneficiary at the time of application.

SEC. 30. Section 12698.10 of the Insurance Code is repealed.

~~12698.10. Coverage provided under this part may be offered to any of a subscriber's children at a monthly premium sufficient to fully cover the cost of coverage for these children, as determined by the board.~~

SEC. 31. Section 12698.30 of the Insurance Code is amended to read:

12698.30. (a) At a minimum, coverage shall be provided to subscribers during one pregnancy, and for 60 days thereafter, and to children less than two years of age who were born of a pregnancy covered under this program to a woman enrolled in the program before July 1, 2004.

(b) Coverage provided pursuant to this part shall include, at a minimum, those services required to be provided by health care service plans approved by the Secretary of Health and Human Services as a federally qualified health care service plan pursuant to Section 417.101 of Title 42 of the Code of Federal Regulations.

1 (c) Coverage shall include health education services related to
2 tobacco use.

3 (d) Medically necessary prescription drugs shall be a required
4 benefit in the coverage provided under this part.

5 *SEC. 32. The heading of Part 6.4 (commencing with Section*
6 *12699.50) of Division 2 of the Insurance Code is amended to read:*

7
8 **PART 6.4. ~~CHILDREN'S~~ COUNTY HEALTH INITIATIVE**
9 **MATCHING FUND**

10
11 *SEC. 33. Section 12699.50 of the Insurance Code is amended*
12 *to read:*

13 12699.50. This part shall be known and may be cited as the
14 ~~Children's~~ County Health Initiative Matching Fund.

15 *SEC. 34. Section 12699.51 of the Insurance Code is amended*
16 *to read:*

17 12699.51. For the purposes of this part, the following
18 definitions shall apply:

19 (a) "Administrative costs" means those expenses that are ~~not~~
20 ~~incurred for the direct provision of health benefits described in~~
21 ~~Section 1397ee(a)(1)(D) of Title 42 of the United States Code.~~

22 (b) "Applicant" means a county, county agency, a local
23 initiative, or a county organized health system.

24 (c) "Board" means the Managed Risk Medical Insurance
25 Board.

26 (d) "Child" means a person under 19 years of age.

27 (e) "Comprehensive health insurance coverage" means the
28 coverage described in Section 12693.60.

29 (f) "County organized health system" means a health system
30 implemented pursuant to Article 2.8 (commencing with Section
31 14087.5) of Chapter 7 of Part 3 of Division 9 of the Welfare and
32 Institutions Code and Article 1 (commencing with Section
33 101675) of Chapter 3 of Part 4 of Division 101 of the Health and
34 Safety Code.

35 (g) "Fund" means the ~~Children's~~ County Health Initiative
36 Matching Fund.

37 (h) "Local initiative" has the same meaning as set forth in
38 Section 12693.08.

39 *SEC. 35. Section 12699.52 of the Insurance Code is amended*
40 *to read:*

12699.52. (a) The ~~Children's~~ County Health Initiative Matching Fund is hereby ~~established~~ *created* within the State Treasury. The fund shall accept intergovernmental transfers as the nonfederal matching fund requirement for federal financial participation through the State Children's Health Insurance Program (Subchapter 21 (commencing with Section 1397aa) of Chapter 7 of Title 42 of the United States Code).

(b) *Amounts deposited in the fund shall be used only for the purposes specified by this part.*

(c) The board shall administer this fund and the provisions of this part in collaboration with the State Department of Health Services for the express purpose of allowing local funds to be used to facilitate increasing the state's ability to utilize federal funds available to California. These federal funds shall be used prior to the expiration of their authority for ~~one-time~~ programs designed to improve and expand access for uninsured persons.

(d) *The board shall authorize the expenditure of money in the fund to cover program expenses, including cost to the state to administer the program.*

SEC. 36. *Section 12699.53 of the Insurance Code is amended to read:*

12699.53. (a) An applicant that will provide an intergovernmental transfer may submit a proposal to the board for funding for the purpose of providing comprehensive health insurance coverage to any child who meets citizenship and immigration status requirements that are applicable to persons participating in the program established by Title XXI of the Social Security Act, ~~except as specified in Section 12693.76~~, whose family income is at or below 300 percent of the federal poverty level in specific geographic areas, as published quarterly in the Federal Register by the Department of Health and Human Services, and who does not qualify for either the Healthy Families Program (Part 6.2 (commencing with Section 12693) or *Medi-Cal* with no share of cost pursuant to the Medi-Cal Act (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code). ~~The~~

(b) *The proposal shall guarantee at least one year of intergovernmental transfer funding by the applicant at a level that ensures compliance with the requirements of an approved federal waiver and shall, on an annual basis, either commit to fully funding*

1 the necessary intergovernmental amount to meet the conditions of
2 the waiver or withdraw from the program. The board may identify
3 specific geographical areas that, in comparison to the national
4 level, have a higher cost of living or housing or a greater need for
5 additional health services, using data obtained from the most
6 recent federal census, the federal Consumer Expenditure Survey,
7 or from other sources. The proposal may include an administrative
8 mechanism for outreach and eligibility.

9 ~~(b)~~

10 (c) The applicant may include in its proposal reimbursement of
11 medical, dental, vision, or mental health services delivered to
12 children who are eligible under the State Children's Health
13 Insurance Program (Subchapter 21 (commencing with Section
14 1397aa) of Chapter 7 of Title 42 of the United States Code), if these
15 services are part of an overall program with the measurable goal
16 of enrolling served children in the Healthy Families Program.

17 ~~(e)~~

18 (d) If a child is determined to be eligible for benefits for the
19 treatment of an eligible medical condition under the California
20 Children's Services Program pursuant to Article 5 (commencing
21 with Section 123800) of Chapter 3 of Part 2 of Division 106 of the
22 Health and Safety Code, ~~the applicant health, dental, or vision~~
23 *plan providing services to the child pursuant to this part* shall not
24 be responsible for the provision of, or payment for, those
25 authorized services for that child. The proposal from an applicant
26 shall contain provisions to ensure that a child whom the ~~applicant~~
27 *health, dental, or vision plan* reasonably believes would be eligible
28 for services under the California Children's Services Program is
29 referred to that program. The California Children's Services
30 Program shall provide case management and authorization of
31 services if the child is found to be eligible for the California
32 Children's Services Program. Diagnosis and treatment services
33 that are authorized by the California Children's Services Program
34 shall be performed by paneled providers for that program and
35 approved special care centers of that program and approved by the
36 California Children's Services Program. All other services
37 provided under the proposal from the applicant shall be made
38 available pursuant to this part to a child who is eligible for services
39 under the California Children's Services Program.

1 SEC. 37. Section 12699.54 of the Insurance Code is amended
2 to read:

3 12699.54. (a) The board ~~and, in consultation with the State~~
4 Department of Health Services, ~~in consultation with participating~~
5 ~~entities, including the Healthy Families Advisory Committee, and~~
6 other appropriate parties, shall establish the criteria for evaluating
7 an applicant's proposal, which shall include, but not be limited to,
8 the following:

9 (1) The extent to which the program described in the proposal
10 provides comprehensive coverage including health, dental, and
11 vision benefits.

12 (2) Whether the proposal includes a promotional component to
13 notify the public of its provision of health insurance to eligible
14 children.

15 (3) The simplicity of the proposal's procedures for applying to
16 participate and for determining eligibility for participation in its
17 program.

18 (4) The extent to which the proposal provides for coordination
19 and conformity with benefits provided through Medi-Cal and the
20 Healthy Families Program.

21 (5) The extent to which the proposal provides for coordination
22 and conformity with existing Healthy Families Program
23 administrative entities in order to prevent administrative
24 duplication and fragmentation.

25 (6) The ability of the health care providers designated in the
26 proposal to serve the eligible population and the extent to which
27 the proposal includes traditional and safety net providers, as
28 defined in regulations adopted pursuant to the Healthy Families
29 Program.

30 (7) The extent to which the proposal intends to work with the
31 school districts and county offices of education.

32 (8) The total amount of funds available to the applicant to
33 implement the program described in its proposal, and the
34 percentage of this amount proposed for administrative costs as
35 well as the cost to the state to administer the proposal.

36 (9) The extent to which the proposal seeks to minimize the
37 substitution of private employer health insurance coverage for
38 health benefits provided through a governmental source.

39 (10) The extent to which local resources may be available after
40 the depletion of federal funds to continue any current program

1 expansions for persons covered under local health care financing
2 programs or for expanded benefits.

3 (b) ~~The board may, in collaboration with the State Department~~
4 ~~of Health Services, shall adopt regulations, setting forth the~~
5 ~~criteria it uses to evaluate an applicant's proposal~~ *its discretion,*
6 *approve or disapprove projects for funding pursuant to this part on*
7 *an annual basis.*

8 (c) *To the extent that an applicant's proposal pursuant to this*
9 *part provides for health plan or administrative services under a*
10 *contract entered into by the board or at rates negotiated for the*
11 *applicant by the board, a contract entered into by the board or by*
12 *an applicant shall be exempt from any provision of law relating to*
13 *competitive bidding, and shall be exempt from the review or*
14 *approval of any division of the Department of General Services to*
15 *the same extent as contracts entered into pursuant to Part 6.2*
16 *(commencing with Section 12693). The board and the applicant*
17 *shall not be required to specify the amounts encumbered for each*
18 *contract, but may allocate funds to each contract based on the*
19 *projected or actual subscriber enrollments to a total amount not*
20 *to exceed the amount appropriated for the project including family*
21 *contributions.*

22 SEC. 38. *Section 12699.56 of the Insurance Code is amended*
23 *to read:*

24 12699.56. (a) Upon its approval of a proposal, the board, in
25 collaboration with the State Department of Health Services, may
26 provide the applicant reimbursement in an amount equal to the
27 amount that the applicant will contribute to implement the
28 program described in its proposal, plus the appropriate and
29 allowable amount of federal funds under the State Children's
30 Health Insurance Program (Subchapter 21 (commencing with
31 Section 1397aa) of Chapter 7 of Title 42 of the United States
32 Code). ~~Reimbursement provided from the Children's Health~~
33 ~~Initiative Matching Fund shall consist of intergovernmental~~
34 ~~transfers from applicants, as defined in subdivision (b) of Section~~
35 ~~12699.51, and the appropriate and allowable federal State~~
36 ~~Children's Health Insurance Program funds.~~ Not more than 10
37 percent of the ~~Children's County Health Initiative Matching Fund~~
38 *and matching federal funds* shall be expended *in any one fiscal*
39 *year* for administrative costs, including the costs to the state to
40 administer the proposal, *unless the board permits the expenditure*

consistent with the availability of federal matching funds not needed for the purposes described in paragraph (3) of subdivision (a) of Section 12699.62. The board, in collaboration with the State Department of Health Services, may audit the expenses incurred by the applicant in implementing its program to ensure that the expenditures comply with the provisions of this part. No reimbursement may be made to an applicant that fails to meet its financial participation obligation under this part. ~~Reasonable~~ The state's reasonable startup costs and ongoing administrative costs for administering the program shall be reimbursed by those entities applying for funding.

(b) Each applicant that is provided funds under this part shall submit to the board a plan to limit initial and continuing enrollment in its program in the event the amount of moneys for its program is insufficient to maintain health insurance coverage for those participating in the program.

SEC. 39. Section 12699.58 of the Insurance Code is amended to read:

12699.58. (a) The board, in collaboration with the State Department of Health Services, shall administer the provisions of this part and may do all of the following:

~~(a)~~
(1) Administer the expenditure of moneys from the fund.
~~(b) Adopt regulations, including the adoption of emergency regulations, in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).~~

(2) Issue rules and regulations as necessary.
(3) Enter into contracts.
(4) Sue and be sued.
(5) Employ necessary staff.
(6) Exercise all powers reasonably necessary to carry out the powers and responsibilities expressly granted or imposed by this part.

(b) The adoption and readoption of regulations pursuant to this section shall be deemed to be an emergency and necessary for the immediate preservation of public peace, health, and safety, or general welfare and shall be exempt from review by the Office of Administrative Law. Any emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for

1 *filing with the Secretary of State and publication in the California*
2 *Code of Regulations and shall remain in effect for not more than*
3 *180 days. The regulation shall become effective immediately upon*
4 *filing with the Secretary of State.*

5 *SEC. 40. Section 12699.60 of the Insurance Code is amended*
6 *to read:*

7 12699.60. Nothing in this part creates a right or an entitlement
8 to the provision of health insurance coverage or health care
9 benefits. No costs shall accrue to the state for the provision of these
10 services. *The state shall not be liable beyond the assets of the fund*
11 *for any obligation incurred or liabilities sustained by applicants*
12 *in the operation of the fund or of the projects authorized by this*
13 *part.*

14 *SEC. 41. Section 12699.61 of the Insurance Code is amended*
15 *to read:*

16 12699.61. ~~The~~ *To the extent necessary to obtain federal*
17 *financial participation for projects approved pursuant to this part,*
18 *the Governor, in collaboration with the Managed Risk Medical*
19 *Insurance Board and the State Department of Health Services,*
20 *shall apply for a waiver one or more waivers or shall file state plan*
21 *amendments pursuant to the federal State Children's Health*
22 *Insurance Program (Subchapter 21 (commencing with Section*
23 *1397aa) of Chapter 7 of Title 42 of the United States Code) in*
24 *coordination with the Managed Risk Medical Insurance Board and*
25 *the State Department of Health Services to allow a county agency,*
26 *local initiative, or county organized health system to apply for*
27 *matching funds through the federal State Children's Health*
28 *Insurance Program (Subchapter 21 (commencing with Section*
29 *1397aa) of Chapter 7 of Title 42 of the United States Code) using*
30 *local funds for the state matching funds.*

31 *SEC. 42. Section 12699.62 of the Insurance Code is amended*
32 *to read:*

33 12699.62. (a) The provisions of this part shall be
34 implemented only if all of the following conditions are met:

35 (1) ~~Federal funds are appropriated~~ *financial participation is*
36 *available for this purpose.*

37 (2) Federal participation is approved.

38 (3) The Managed Risk Medical Insurance Board determines
39 that federal State Children's Health Insurance Program
40 *(Subchapter 21 (commencing with Section 1397aa) of Chapter 7*

of Title 42 of the United States Code) funds will remain available in the relevant fiscal year after providing funds for the following groups:

(A) All current enrollees and eligible children and parents that are likely to enroll in the Healthy Families Program in that fiscal year and, to the extent funded through the federal State Children's Health Insurance Program, the Access for Infants and Mothers Program and Medi-Cal program, as determined by a Department of Finance estimate.

(B) Rollover funds are determined to be available from the State Children's Health Insurance Program. For this purpose, "rollover funds" are those funds that are available on a one-time only basis through the federal State Children's Health Insurance Program (Subchapter 21 (commencing with Section 1397aa) of Chapter 7 of Title 42 of the United States Code) and are not committed for use by those groups described in subparagraph (A).

(4) Funds are appropriated specifically for this purpose.

(b) The State Department of Health Services and the Managed Risk Medical Insurance Board may accept funding necessary for the preparation of the federal waiver-application applications or state plan amendments described in Section 12699.61 from a not-for-profit group or foundation.

(c) The submission and approval of federal waivers for State Children's Health Insurance Program funds that use state General Fund moneys for the addition of children or parents shall take precedence over the submittal of the waiver required by Section 12699.61.

SEC. 43. Section 1026.2 of the Penal Code is amended to read:

1026.2. (a) An application for the release of a person who has been committed to a state hospital or other treatment facility, as provided in Section 1026, upon the ground that sanity has been restored, may be made to the superior court of the county from which the commitment was made, either by the person, or by the medical director of the state hospital or other treatment facility to which the person is committed or by the community program director where the person is on outpatient status under Title 15 (commencing with Section 1600). The court shall give notice of the hearing date to the prosecuting attorney, the community program director or a designee, and the medical director or person

1 in charge of the facility providing treatment to the committed
2 person at least 15 judicial days in advance of the hearing date.

3 (b) Pending the hearing, the medical director or person in
4 charge of the facility in which the person is confined shall prepare
5 a summary of the person's programs of treatment and shall forward
6 the summary to the community program director or a designee and
7 to the court. The community program director or a designee shall
8 review the summary and shall designate a facility within a
9 reasonable distance from the court in which the person may be
10 detained pending the hearing on the application for release. The
11 facility so designated shall continue the program of treatment,
12 shall provide adequate security, and shall, to the greatest extent
13 possible, minimize interference with the person's program of
14 treatment.

15 (c) A designated facility need not be approved for 72-hour
16 treatment and evaluation pursuant to the Lanterman-Petris-Short
17 Act (Part 1 (commencing with Section 5000) of Division 5 of the
18 Welfare and Institutions Code). However, a county jail may not be
19 designated unless the services specified in subdivision (b) are
20 provided and accommodations are provided which ensure both the
21 safety of the person and the safety of the general population of the
22 jail. If there is evidence that the treatment program is not being
23 complied with or accommodations have not been provided which
24 ensure both the safety of the committed person and the safety of
25 the general population of the jail, the court shall order the person
26 transferred to an appropriate facility or make any other appropriate
27 order, including continuance of the proceedings.

28 (d) No hearing upon the application shall be allowed until the
29 person committed has been confined or placed on outpatient status
30 for a period of not less than 180 days from the date of the order of
31 commitment.

32 (e) The court shall hold a hearing to determine whether the
33 person applying for restoration of sanity would be a danger to the
34 health and safety of others, due to mental defect, disease, or
35 disorder, if under supervision and treatment in the community. If
36 the court at the hearing determines the applicant will not be a
37 danger to the health and safety of others, due to mental defect,
38 disease, or disorder, while under supervision and treatment in the
39 community, the court shall order the applicant placed with an
40 appropriate forensic conditional release program for one year. All

1 or a substantial portion of the program shall include outpatient
2 supervision and treatment. The court shall retain jurisdiction. The
3 court at the end of the one year, shall have a trial to determine if
4 sanity has been restored, which means the applicant is no longer
5 a danger to the health and safety of others, due to mental defect,
6 disease, or disorder. The court shall not determine whether the
7 applicant has been restored to sanity until the applicant has
8 completed the one year in the appropriate forensic conditional
9 release program, unless the community program director sooner
10 makes a recommendation for restoration of sanity and
11 unconditional release as described in subdivision (h). The court
12 shall notify the persons required to be notified in subdivision (a)
13 of the hearing date.

14 (f) If the applicant is on parole or outpatient status and has been
15 on it for one year or longer, then it is deemed that the applicant has
16 completed the required one year in an appropriate forensic
17 conditional release program and the court shall, if all other
18 applicable provisions of law have been met, hold the trial on
19 restoration of sanity as provided for in this section.

20 (g) Before placing an applicant in an appropriate forensic
21 conditional release program, the community program director
22 shall submit to the court a written recommendation as to what
23 forensic conditional release program is the most appropriate for
24 supervising and treating the applicant. If the court does not accept
25 the community program director's recommendation, the court
26 shall specify the reason or reasons for its order on the court record.
27 Sections 1605 to 1610, inclusive, shall be applicable to the person
28 placed in the forensic conditional release program unless
29 otherwise ordered by the court.

30 (h) If the court determines that the person should be transferred
31 to an appropriate forensic conditional release program, the
32 community program director or a designee shall make the
33 necessary placement arrangements, and, within 21 days after
34 receiving notice of the court finding, the person shall be placed in
35 the community in accordance with the treatment and supervision
36 plan, unless good cause for not doing so is made known to the
37 court.

38 During the one year of supervision and treatment, if the
39 community program director is of the opinion that the person is no
40 longer a danger to the health and safety of others due to a mental

1 defect, disease, or disorder, the community program director shall
2 submit a report of his or her opinion and recommendations to the
3 committing court, the prosecuting attorney, and the attorney for
4 the person. The court shall then set and hold a trial to determine
5 whether restoration of sanity and unconditional release should be
6 granted. The trial shall be conducted in the same manner as is
7 required at the end of one full year of supervision and treatment.

8 (i) If at the trial for restoration of sanity the court rules
9 adversely to the applicant, the court may place the applicant on
10 outpatient status, pursuant to Title 15 (commencing with Section
11 1600) of Part 2, unless the applicant does not meet all of the
12 requirements of Section 1603.

13 (j) If the court denies the application to place the person in an
14 appropriate forensic conditional release program or if restoration
15 of sanity is denied, no new application may be filed by the person
16 until one year has elapsed from the date of the denial.

17 (k) In any hearing authorized by this section, the applicant shall
18 have the burden of proof by a preponderance of the evidence.

19 (l) If the application for the release is not made by the medical
20 director of the state hospital or other treatment facility to which the
21 person is committed or by the community program director where
22 the person is on outpatient status under Title 15 (commencing with
23 Section 1600), no action on the application shall be taken by the
24 court without first obtaining the written recommendation of the
25 medical director of the state hospital or other treatment facility or
26 of the community program director where the person is on
27 outpatient status under Title 15 (commencing with Section 1600).

28 (m) *This subdivision shall apply only to persons who, at the*
29 *time of the petition or recommendation for restoration of sanity,*
30 *are subject to a term of imprisonment with prison time remaining*
31 *to serve or are subject to the imposition of a previously stayed*
32 *sentence to a term of imprisonment. Any person to whom this*
33 *subdivision applies who petitions or is recommended for*
34 *restoration of sanity may not be placed in a forensic conditional*
35 *release program for one year, and a finding of restoration of sanity*
36 *may be made without the person being in a forensic conditional*
37 *release program for one year. If a finding of restoration of sanity*
38 *is made, the person shall be transferred to the custody of the*
39 *California Department of Corrections to serve the term of*
40 *imprisonment remaining or shall be transferred to the appropriate*

1 *court for imposition of the sentence that is pending, whichever is*
2 *applicable.*

3 *SEC. 44. Section 4094.2 of the Welfare and Institutions Code*
4 *is amended to read:*

5 4094.2. (a) For the purpose of establishing payment rates for
6 community treatment facility programs, the private nonprofit
7 agencies selected to operate these programs shall prepare a budget
8 that covers the total costs of providing residential care and
9 supervision and mental health services for their proposed
10 programs. These costs shall include categories that are allowable
11 under California's Foster Care program and existing programs for
12 mental health services. They shall not include educational,
13 nonmental health medical, and dental costs.

14 (b) Each agency operating a community treatment facility
15 program shall negotiate a final budget with the local mental health
16 department in the county in which its facility is located (the host
17 county) and other local agencies, as appropriate. This budget
18 agreement shall specify the types and level of care and services to
19 be provided by the community treatment facility program and a
20 payment rate that fully covers the costs included in the negotiated
21 budget. All counties that place children in a community treatment
22 facility program shall make payments using the budget agreement
23 negotiated by the community treatment facility provider and the
24 host county.

25 (c) A foster care rate shall be established for each community
26 treatment facility program by the State Department of Social
27 Services. These rates shall be established using the existing foster
28 care ratesetting system for group homes, with modifications
29 designed as necessary. It is anticipated that all community
30 treatment facility programs will offer the level of care and services
31 required to receive the highest foster care rate provided for under
32 the current group home ratesetting system.

33 (d) For the 2001–02 fiscal year~~and~~, the 2002–03 fiscal year,
34 *and the 2003–04 fiscal year*, community treatment facility
35 programs shall also be paid a community treatment facility
36 supplemental rate of up to two thousand five hundred dollars
37 (\$2,500) per child per month on behalf of children eligible under
38 the foster care program and children placed out of home pursuant
39 to an individualized education program developed under Section
40 7572.5 of the Government Code. Subject to the availability of

1 funds, the supplemental rate shall be shared by the state and the
2 counties. Counties shall be responsible for paying a county share
3 of cost equal to 60 percent of the community treatment rate for
4 children placed by counties in community treatment facilities and
5 the state shall be responsible for 40 percent of the community
6 treatment facility supplemental rate. The community treatment
7 facility supplemental rate is intended to supplement, and not to
8 supplant, the payments for which children placed in community
9 treatment facilities are eligible to receive under the foster care
10 program and the existing programs for mental health services.

11 (e) For initial ratesetting purposes for community treatment
12 facility funding, the cost of mental health services shall be
13 determined by deducting the foster care rate and the community
14 treatment facility supplemental rate from the total allowable cost
15 of the community treatment facility program. Payments to
16 certified providers for mental health services shall be based on
17 eligible services provided to children who are Medi-Cal
18 beneficiaries, up to the statewide maximum allowances for these
19 services.

20 (f) Although there is statutory authorization for up to 400
21 community treatment facility beds statewide, it is anticipated that
22 there will be a phased-in implementation of community treatment
23 facilities, and that the average monthly community treatment
24 facility caseload ~~during, by fiscal year, will be as follows:~~

25 (1) ~~During the 2001–02 fiscal year will be, approximately 100~~
26 ~~and during the.~~

27 (2) ~~During the 2002–03 fiscal year will be, approximately 140.~~

28 (3) ~~During the 2003–04 fiscal year, approximately 175.~~

29 (g) The department shall provide the community treatment
30 facility supplemental rates to the counties for advanced payment
31 to the community treatment facility providers in the same manner
32 as the regular foster care payment and within the same required
33 payment time limits.

34 (h) In order to facilitate a study of the costs of community
35 treatment facilities, licensed community treatment facilities shall
36 provide all documents regarding facility operations, treatment,
37 and placements requested by the department.

38 (i) It is the intent of the Legislature that the department and the
39 State Department of Social Services work to maximize federal
40 financial participation in funding for children placed in

community treatment facilities through funds available pursuant to Titles IV-E and XIX of the federal Social Security Act (Title 42 U.S.C. Sec. 670 and following and Sec. 1396 and following) and other appropriate federal programs.

(j) The department and the State Department of Social Services may adopt emergency regulations necessary to implement joint protocols for the oversight of community treatment facilities, to modify existing licensing regulations governing reporting requirements and other procedural and administrative mandates to take into account the seriousness and frequency of behaviors that are likely to be exhibited by the seriously emotionally disturbed children placed in community treatment facility programs, to modify the existing foster care ratesetting regulations, and to pay the community treatment facility supplemental rate. The adoption of these regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, and general welfare. The regulations shall become effective immediately upon filing with the Secretary of State. The regulations shall not remain in effect more than 180 days unless the adopting agency complies with all the provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, as required by subdivision (e) of Section 11346.1 of the Government Code.

SEC. 45. Section 4433 of the Welfare and Institutions Code is amended to read:

4433. (a) The Legislature finds and declares all of the following:

(1) The State of California accepts its responsibility to ensure and uphold the rights of persons with developmental disabilities and an obligation to ensure that laws, regulations, and policies on the rights of persons with developmental disabilities are observed and protected.

(2) Persons with developmental disabilities are vulnerable to abuse, neglect, and deprivations of their rights.

(3) Clients' rights advocacy services provided by the regional centers, the advocacy services currently provided by the department at the state hospitals, and the services provided by the department's Office of Human Rights may have conflicts of interest, or the appearance of a conflict of interest.

(4) The services provided to individuals with developmental disabilities and their families are of such a special and unique nature that they cannot satisfactorily be provided by state agencies or regional centers and must be contracted out pursuant to paragraph (3) of subdivision (b) of Section 19130 of the Government Code.

(b) (1) To avoid the potential for a conflict of interest or the appearance of a conflict of interest, beginning January 1, 1998, the department shall contract for clients' rights advocacy services. The department shall solicit a single statewide contract with a nonprofit agency that results in at least three responsive bids that meet all of the criteria specified in paragraph (2) to perform the services specified in subdivision (d). If three responsive bids are not received, the department may rebid the contract on a regional basis, not to exceed three regional contracts and one contract for developmental centers and headquarters.

(2) Any contractor selected shall meet the following requirements:

(A) The contractor can demonstrate the capability to provide statewide advocacy services to individuals with developmental disabilities living in developmental centers and in the community.

(B) The contractor does not directly or indirectly provide services to individuals with developmental disabilities, except advocacy services.

(C) The contractor has knowledge of the service system, entitlements, and service rights of persons receiving services from regional centers and in state hospitals.

(D) The contractor can demonstrate the capability of coordinating services with the protection and advocacy agency specified in Division 4.7 (commencing with Section 4900) and the area boards.

(E) The contractor has not provided any services, except advocacy services, to, or been employed by, any regional center or the Association of Regional Center Agencies during the two-year period prior to the effective date of the contract.

(c) For the purposes of this section, the Legislature further finds and declares that because of a potential conflict of interest or the appearance of a conflict of interest, the goals and purposes of the regional center clients' rights advocacy services, the state hospitals, and the services of the Office of Human Rights, cannot

1 be accomplished through the utilization of persons selected
2 pursuant to the regular civil service system, nor can the services be
3 provided through the department's contracts with regional centers.
4 Accordingly, contracts into which the department enters pursuant
5 to this section are permitted and authorized by paragraphs (3) and
6 (5) of subdivision (b) of Section 19130 of the Government Code.

7 (d) The contractor shall do all of the following:

8 (1) Provide clients' rights advocacy services to persons with
9 developmental disabilities who are consumers of regional centers
10 and to individuals who reside in the state developmental centers
11 and hospitals, including ensuring the rights of persons with
12 developmental disabilities, and assisting persons with
13 developmental disabilities in pursuing administrative and legal
14 remedies.

15 (2) Investigate and take action as appropriate and necessary to
16 resolve complaints from, or concerning persons with,
17 developmental disabilities residing in licensed health and
18 community care facilities regarding abuse, and unreasonable
19 denial, or punitive withholding, of rights guaranteed under this
20 division.

21 (3) Provide consultation, technical assistance, supervision and
22 training, and support services for clients' rights advocates that
23 were previously the responsibility of the Office of Human Rights.

24 (4) Coordinate the provision of clients' rights advocacy
25 services in consultation with the department, stakeholder
26 organizations, and persons with developmental disabilities and
27 their families representing California's multicultural diversity.

28 (5) Provide at least two self-advocacy trainings for consumers
29 and family members.

30 (e) In order to ensure that individuals with developmental
31 disabilities have access to high quality advocacy services, the
32 contractor shall establish a grievance procedure and shall advise
33 persons receiving services under the contract of the availability of
34 other advocacy services, including the services provided by the
35 protection and advocacy agency specified in Division 4.7
36 (commencing with Section 4900) and the area boards.

37 (f) The department shall contract on a multiyear basis for a
38 contract term of up to ~~three~~ *five* years, subject to the annual
39 appropriation of funds by the Legislature.

(g) This section shall not prohibit the department and the regional centers from advocating for the rights, including the right to generic services, of persons with developmental disabilities.

SEC. 46. Section 4512 of the Welfare and Institutions Code is amended to read:

4512. As used in this ~~part~~ *division*:

(a) “Developmental disability” means a disability ~~which~~ *that* originates before an individual attains age 18 years, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, this term shall include mental retardation, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation, but shall not include other handicapping conditions that are solely physical in nature.

(b) “Services and supports for persons with developmental disabilities” means specialized services and supports or special adaptations of generic services and supports directed toward the alleviation of a developmental disability or toward the social, personal, physical, or economic habilitation or rehabilitation of an individual with a developmental disability, or toward the achievement and maintenance of independent, productive, normal lives. The determination of which services and supports are necessary for each consumer shall be made through the individual program plan process. The determination shall be made on the basis of the needs and preferences of the consumer or, when appropriate, the consumer’s family, and shall include consideration of a range of service options proposed by individual program plan participants, the effectiveness of each option in meeting the goals stated in the individual program plan, and the cost-effectiveness of each option. Services and supports listed in the individual program plan may include, but are not limited to, diagnosis, evaluation, treatment, personal care, day care, domiciliary care, special living arrangements, physical, occupational, and speech therapy, training, education, supported and sheltered employment, mental health services, recreation, counseling of the individual with a developmental disability and

1 of his or her family, protective and other social and sociolegal
 2 services, information and referral services, follow-along services,
 3 adaptive equipment and supplies; advocacy assistance, including
 4 self-advocacy training, facilitation and peer advocates;
 5 assessment; assistance in locating a home; child care; behavior
 6 training and behavior modification programs; camping;
 7 community integration services; community support; daily
 8 living skills training; emergency and crisis intervention;
 9 facilitating circles of support; habilitation; homemaker
 10 services; infant stimulation programs; paid roommates; paid
 11 neighbors; respite; short-term out-of-home care; social skills
 12 training; specialized medical and dental care; supported living
 13 arrangements; technical and financial assistance; travel
 14 training; training for parents of children with developmental
 15 disabilities; training for parents with developmental disabilities;
 16 vouchers; and transportation services necessary to ensure
 17 delivery of services to persons with developmental disabilities.
 18 Nothing in this subdivision is intended to expand or authorize a
 19 new or different service or support for any consumer unless that
 20 service or support is contained in his or her individual program
 21 plan.

22 (c) Notwithstanding ~~subdivision~~ *subdivisions* (a) and (b), for
 23 any organization or agency receiving federal financial
 24 participation under the federal Developmental Disabilities
 25 Assistance and Bill of Rights Act, as amended “developmental
 26 disability” and “services for persons with developmental
 27 disabilities” means ~~such~~ *the* terms as defined in the federal act to
 28 the extent required by federal law.

29 (d) “Consumer” means a person who has a disability that
 30 meets the definition of developmental disability set forth in
 31 subdivision (a).

32 (e) “Natural supports” means personal associations and
 33 relationships typically developed in the community that enhance
 34 the quality and security of life for people, including, but not
 35 limited to, family relationships; friendships reflecting the
 36 diversity of the neighborhood and the community; associations
 37 with fellow students or employees in regular classrooms and
 38 workplaces; and associations developed through participation in
 39 clubs, organizations, and other civic activities.



1 (f) “Circle of support” means a committed group of
2 community members,~~which~~ *who* may include family members,
3 meeting regularly with an individual with developmental
4 disabilities in order to share experiences, promote autonomy and
5 community involvement, and assist the individual in establishing
6 and maintaining natural supports. ~~Such a~~ A circle of support
7 generally includes a plurality of members who neither provide nor
8 receive services or supports for persons with developmental
9 disabilities and who do not receive payment for participation in the
10 circle of support.

11 (g) “Facilitation” means the use of modified or adapted
12 materials, special instructions, equipment, or personal assistance
13 by an individual, such as assistance with communications,~~which~~
14 *that* will enable a consumer to understand and participate to the
15 maximum extent possible in the decisions and choices~~which~~ *that*
16 effect his or her life.

17 (h) “Family support services” means services and supports
18 that are provided to a child with developmental disabilities or his
19 or her family and that contribute to the ability of the family to
20 reside together.

21 (i) “Voucher” means any authorized alternative form of
22 service delivery in which the consumer or family member is
23 provided with a payment, coupon, chit, or other form of
24 authorization~~which~~ *that* enables the consumer or family member
25 to choose his or her own service provider.

26 (j) “Planning team” means the individual with developmental
27 disabilities, the parents or legally appointed guardian of a minor
28 consumer; or the legally appointed conservator of an adult
29 consumer, the authorized representative, including those
30 appointed pursuant to *subdivision (d) of Section 4590-4548* and
31 subdivision (e) of Section 4705, one or more regional center
32 representatives, including the designated regional center service
33 coordinator pursuant to subdivision (b) of Section 4640.7,~~and~~ any
34 individual, including a service provider, invited by the consumer,
35 the parents or legally appointed guardian of a minor consumer; or
36 the legally appointed conservator of an adult consumer, or the
37 authorized representative, including those appointed pursuant to
38 Section 4590 and subdivision (e) of Section 4705.

39 (k) “Stakeholder organizations” means statewide
40 organizations representing the interests of consumers, family

1 members, service providers, and statewide advocacy
2 organizations.

3 (1) “Substantial disability” means the existence of significant
4 functional limitations in three or more of the following areas of
5 major life activity, as determined by a regional center, and as
6 appropriate to the age of the person:

7 (1) Self-care.

8 (2) Receptive and expressive language.

9 (3) Learning.

10 (4) Mobility.

11 (5) Self-direction.

12 (6) Capacity for independent living.

13 (7) Economic self-sufficiency.

14 SEC. 47. Section 4620.2 is added to the Welfare and
15 Institutions Code, to read:

16 4620.2. (a) The State Department of Developmental
17 Services, after consultation with stakeholder groups, shall develop
18 a system of enrollment fees, copayments, or both, to be assessed
19 against the parents of each child between the ages of three and 17
20 years who lives in the parent’s home and receives services
21 purchased through a regional center. This system shall be
22 submitted to the Legislature on or before April 1, 2004,
23 immediately prior to the fiscal year in which the system is to be
24 implemented, and as a part of the Governor’s proposed 2004–05
25 budget or subsequent legislation.

26 (b) The department, after consultation with stakeholder
27 groups, shall submit a detailed plan for implementing a parental
28 copayment system for children receiving services purchased
29 through a regional center. This plan shall be submitted to the
30 Legislature by April 1, 2004.

31 (c) The plan submitted on or before April 1, 2004, pursuant to
32 subdivision (b), and any resources requested in the 2004–05
33 Governor’s Budget and related authority may be subsequently
34 modified during the legislative review process.

35 (d) The parental copayment system shall only be applicable to
36 families that have adjusted gross family incomes of over 200
37 percent of the federal poverty level and that have a child who meets
38 all of the following criteria:

39 (1) The child is receiving services purchased through a
40 regional center.

- 1 (2) *The child is living at home.*
- 2 (3) *The child is not otherwise eligible to receive services*
- 3 *provided under the Medi-Cal program.*
- 4 (4) *The child is at least three years of age and not more than 17*
- 5 *years of age.*
- 6 (e) *The department's plan shall address, at a minimum all of the*
- 7 *following components for the development of a parental*
- 8 *copayment system:*
- 9 (1) *Description of the families and children affected, including*
- 10 *those families with more than one child as described under*
- 11 *subdivision (d).*
- 12 (2) *Privacy issues and potential safeguards regarding the*
- 13 *families' income, the children's regional center clinical records,*
- 14 *and related matters.*
- 15 (3) *Schedule of parental copayments and any other related*
- 16 *assessments, and criteria or service thresholds for which these*
- 17 *copayments and assessments are based.*
- 18 (4) *The options for a sliding scale for the schedule of parental*
- 19 *copayments based on family income and family size.*
- 20 (5) *Proposed limits on parental cost sharing.*
- 21 (6) *An exemption process for families who are experiencing*
- 22 *financial hardships and may need deferral or waiver of any*
- 23 *copayments or assessments.*
- 24 (7) *An appeal process for families who may dispute the level of*
- 25 *copayment or assessments for which they are billed.*
- 26 (8) *The specific methods and processes to be used by the*
- 27 *department, regional centers, or other responsible party, for the*
- 28 *collection of all parental copayments and assessments.*
- 29 (9) *Any potentials for the disruption of services to applicable*
- 30 *regional center consumers due to the implementation of a parental*
- 31 *copayment system.*
- 32 (10) *The estimated amount of revenues to be collected and any*
- 33 *applicable assumptions made for making this determination.*
- 34 (11) *Any estimate related to a slowing of the trend in the growth*
- 35 *for regional center services due to the implementation of a parental*
- 36 *copayment system.*
- 37 (12) *A comparison to how the State Department of Health*
- 38 *Services and other state agencies utilize personal information to*
- 39 *manage the delivery of benefits and assessment of copayments.*



1 (13) A recommendation on whether the parental copayment
2 system should be centralized at the department or decentralized in
3 the regional centers and the basis for this recommendation.

4 (14) The estimated cost for implementing a parental copayment
5 system, including any costs associated with consultant contracts,
6 state personnel, revenue collection, computer system processing,
7 regional center operations, or any other cost factor that would
8 need to be included in order to capture all estimated costs for
9 implementation.

10 (15) The timeframe for which the parental copayment system is
11 to be implemented.

12 (f) (1) In order for the department to develop a detailed plan
13 for the implementation of a parental copayment system, the
14 department shall collect information from selected families. In
15 order to be cost-efficient and prudent regarding the collection of
16 information, the department may conduct a survey of only those
17 families known to have children not eligible for the Medi-Cal
18 program. The survey instrument may only be used for the sole
19 purpose of obtaining information that is deemed necessary for the
20 development of a parental copayment system, including the
21 following:

22 (A) A family's annual adjusted gross family income.

23 (B) The number of family members dependent on that income.

24 (C) The number of children who meet the criteria specified in
25 subdivision (d).

26 (2) Results of the survey in the aggregate shall be provided to
27 the Legislature as part of the department's plan as required by
28 subdivision (a).

29 SEC. 48. Section 4631.5 of the Welfare and Institutions Code
30 is amended to read:

31 4631.5. (a) The Legislature finds and declares both of the
32 following:

33 (1) The state is facing ~~an unprecedented~~ a fiscal crisis that will
34 require an unallocated reduction in the ~~2002-03~~ 2003-04 fiscal
35 year for regional centers' purchase of service budgets of ~~fifty-two~~
36 three million dollars ~~(\$52,000,000)~~ (\$3,000,000).

37 (2) Even when the state faces an unprecedented fiscal crisis, the
38 services and supports set forth in the Lanterman Developmental
39 Disabilities Services Act (Division 4.5 (commencing with Section
40 4500)) shall continue to be provided to individuals with

1 developmental disabilities in accordance with state and federal
2 statutes, regulations, and case law, including *Association for*
3 *Retarded Citizens v. Department of Developmental Services*
4 (1985) 38 Cal.3d 384.

5 (b) It is the intent of the Legislature that actions taken pursuant
6 to this section shall not eliminate an individual's eligibility,
7 adversely affect an individual's health and safety, or interfere with
8 an individual's rights as described in Section 4502.

9 (c) In order to ensure that services to eligible consumers are
10 available throughout the fiscal year, regional centers shall
11 administer their contracts within the level of funding appropriated
12 by the annual Budget Act.

13 (d) Within 30 days of the enactment of the annual Budget Act,
14 and after consultation with stakeholder organizations, the
15 department shall determine the amount of unallocated reduction
16 that each regional center shall make in its purchase-of-service
17 budget and shall provide each regional center with guidelines,
18 technical assistance, and a variety of options for reducing
19 operations and purchase of service costs.

20 (e) Within 60 days of the enactment of the annual Budget Act,
21 each regional center shall develop and submit a plan to the
22 department describing in detail how it intends to absorb the
23 unallocated reduction and achieve savings necessary to provide
24 services to eligible consumers throughout the fiscal year within the
25 limitations of the funds allocated. Prior to adopting the plan, each
26 regional center shall hold a public hearing in order to receive
27 comment on the plan. The regional center shall provide notice to
28 the community at least 10 days in advance of the public hearing.
29 The regional center shall summarize and respond to the public
30 testimony in its plan.

31 (f) A regional center shall implement components of its plans
32 upon approval of the department. Within 30 days of receipt of the
33 plan, the department shall review and approve, or require
34 modification of, portions of the regional center's plan.

35 (g) This section shall become inoperative on July, 1, 2004
36 2005, and, as of January 1, ~~2005~~ 2006, is repealed, unless a later
37 enacted statute, that becomes operative on or before January 1,
38 ~~2005~~ 2006, deletes or extends the dates on which it becomes
39 inoperative and is repealed.

1 *SEC. 49. Section 4640.6 of the Welfare and Institutions Code*
2 *is amended to read:*

3 4640.6. (a) In approving regional center contracts, the
4 department shall ensure that regional center staffing patterns
5 demonstrate that direct service coordination are the highest
6 priority.

7 (b) Contracts between the department and regional centers
8 shall require that regional centers implement an emergency
9 response system that ensures that a regional center staff person will
10 respond to a consumer, or individual acting on behalf of a
11 consumer, within two hours of the time an emergency call is
12 placed. This emergency response system shall be operational 24
13 hours per day, 365 days per year.

14 (c) Contracts between the department and regional centers
15 shall require regional centers to have service
16 coordinator-to-consumer ratios, as follows:

17 (1) An average service coordinator-to-consumer ratio of 1 to 62
18 for all consumers who have not moved from the developmental
19 centers to the community since April 14, 1993. In no case shall a
20 service coordinator for these consumers have an assigned caseload
21 in excess of 79 consumers for more than 60 days.

22 (2) An average service coordinator-to-consumer ratio of 1 to 45
23 for all consumers who have moved from a developmental center
24 to the community since April 14, 1993. In no case shall a service
25 coordinator for these consumers have an assigned caseload in
26 excess of 59 consumers for more than 60 days.

27 (3) *Commencing January 1, 2004, to June 30, 2007, inclusive,*
28 *the following coordinator-to-consumer ratios shall apply:*

29 (A) *All consumers three years of age and younger and for*
30 *consumers enrolled on the Home and Community-based Services*
31 *Waiver for persons with developmental disabilities, an average*
32 *service coordinator-to-consumer ratio of 1 to 62.*

33 (B) *All consumers who have moved from a developmental*
34 *center to the community since April 14, 1993, and have lived*
35 *continuously in the community for at least 12 months, an average*
36 *service coordinator-to-consumer ratio of 1 to 62.*

37 (C) *All consumers who have not moved from the developmental*
38 *centers to the community since April 14, 1993, and who are not*
39 *described in subparagraph (A), an average service*
40 *coordinator-to-consumer ratio of 1 to 66.*

1 (4) *For purposes of paragraph (3), service coordinators may*
2 *have a mixed caseload of consumers three years of age and*
3 *younger, consumers enrolled on the Home and Community-based*
4 *Services Waiver program for persons with developmental*
5 *disabilities, and other consumers if the overall average caseload*
6 *is weighted proportionately to ensure that overall regional center*
7 *average service coordinator-to-consumer ratios as specified in*
8 *paragraph (3) are met. For purposes of paragraph (3), in no case*
9 *shall a service coordinator have an assigned caseload in excess of*
10 *84 for more than 60 days.*

11 (d) For purposes of this section, “service coordinator” means
12 a regional center employee whose primary responsibility includes
13 preparing, implementing, and monitoring consumers’ individual
14 program plans, securing and coordinating consumer services and
15 supports, and providing placement and monitoring activities.

16 (e) In order to ensure that caseload ratios are maintained
17 pursuant to this section, each regional center shall provide service
18 coordinator caseload data to the department ~~in September and~~
19 ~~March of, annually for each fiscal year, commencing in the~~
20 ~~1999–2000 fiscal year.~~ The data shall be submitted in ~~a~~ *the* format,
21 *including the content*, prescribed by the department. Within 30
22 days of receipt of data submitted pursuant to this subdivision, the
23 department shall make a summary of the data available to the
24 public upon request. The department shall verify the accuracy of
25 the data when conducting regional center fiscal audits. Data
26 submitted by regional centers pursuant to this subdivision shall:

27 (1) Only include data on service coordinator positions as
28 defined in subdivision (d). Regional centers shall identify the
29 number of positions that perform service coordinator duties on less
30 than a full-time basis. Staffing ratios reported pursuant to this
31 subdivision shall reflect the appropriate proportionality of these
32 staff to consumers served.

33 (2) Be reported separately for service coordinators whose
34 caseload ~~primarily~~ includes any of the following:

35 (A) Consumers who are three years of age and older and who
36 have not moved from the developmental center to the community
37 since April 14, 1993.

38 (B) Consumers who have moved from a developmental center
39 to the community since April 14, 1993.

40 (C) Consumers who are younger than three years of age.

1 (D) *Consumers enrolled in the Home and Community-based*
2 *Services Waiver program.*

3 (3) Not include positions that are vacant for more than 60 days
4 *or new positions established within 60 days of the reporting month*
5 *that are still vacant.*

6 (f) The department shall provide technical assistance and
7 require a plan of correction for any regional center that, for two
8 consecutive reporting periods, fails to maintain service
9 coordinator caseload ratios required by this section or otherwise
10 demonstrates an inability to maintain appropriate staffing patterns
11 pursuant to this section. Plans of correction shall be developed
12 following input from the local area board, local organizations
13 representing consumers, family members, regional center
14 employees, including recognized labor organizations, and service
15 providers, and other interested parties.

16 (g) Contracts between the department and regional center shall
17 require the regional center to have, or contract for, all of the
18 following areas:

19 (1) Criminal justice expertise to assist the regional center in
20 providing services and support to consumers involved in the
21 criminal justice system as a victim, defendant, inmate, or parolee.

22 (2) Special education expertise to assist the regional center in
23 providing advocacy and support to families seeking appropriate
24 educational services from a school district.

25 (3) Family support expertise to assist the regional center in
26 maximizing the effectiveness of support and services provided to
27 families.

28 (4) Housing expertise to assist the regional center in accessing
29 affordable housing for consumers in independent or supportive
30 living arrangements.

31 (5) Community integration expertise to assist consumers and
32 families in accessing integrated services and supports and
33 improved opportunities to participate in community life.

34 (6) Quality assurance expertise, to assist the regional center to
35 provide the necessary coordination and cooperation with the area
36 board in conducting quality-of-life assessments and coordinating
37 the regional center quality assurance efforts.

38 (7) Each regional center shall employ at least one consumer
39 advocate who is a person with developmental disabilities.

1 (8) Other staffing arrangements related to the delivery of
2 services that the department determines are necessary to ensure
3 maximum cost-effectiveness and to ensure that the service needs
4 of consumers and families are met.

5 (h) Any regional center proposing a staffing arrangement that
6 substantially deviates from the requirements of this section shall
7 request a waiver from the department. Prior to granting a waiver,
8 the department shall require a detailed staffing proposal,
9 including, but not limited to, how the proposed staffing
10 arrangement will benefit consumers and families served, and shall
11 demonstrate clear and convincing support for the proposed
12 staffing arrangement from constituencies served and impacted,
13 that include, but are not limited to, consumers, families, providers,
14 advocates, and recognized labor organizations. In addition, the
15 regional center shall submit to the department any written
16 opposition to the proposal from organizations or individuals,
17 including, but not limited to, consumers, families, providers, and
18 advocates, including recognized labor organizations. The
19 department may grant waivers to regional centers that sufficiently
20 demonstrate that the proposed staffing arrangement is in the best
21 interest of consumers and families served, complies with the
22 requirements of this chapter, and does not violate any contractual
23 requirements. A waiver shall be approved by the department for
24 up to 12 months, at which time a regional center may submit a new
25 request pursuant to this subdivision.

26 (i) The requirements of subdivisions (c), (f), and (h) shall not
27 apply when a regional center is required to develop an expenditure
28 plan pursuant to Section 4791, and when the expenditure plan
29 addresses the specific impact of the budget reduction on staffing
30 requirements and the expenditure plan is approved by the
31 department.

32 (j) (1) Any contract between the department and a regional
33 center entered into on and after January 1, 2003, shall require that
34 all employment contracts entered into with regional center staff or
35 contractors be available to the public for review, upon request. For
36 purposes of this subdivision, an employment contract or portion
37 thereof may not be deemed confidential nor unavailable for public
38 review.

39 (2) Notwithstanding paragraph (1), the social security number
40 of the contracting party may not be disclosed.

(3) The term of the employment contract between the regional center and an employee or contractor shall not exceed the term of the state's contract with the regional center.

SEC. 50. Section 4643 of the Welfare and Institutions Code is amended to read:

4643. (a) If assessment is needed, prior to July 1, ~~2003~~ 2004, the assessment shall be performed within 120 days following initial intake. Assessment shall be performed as soon as possible and in no event more than 60 days following initial intake where any delay would expose the client to unnecessary risk to his or her health and safety or to significant further delay in mental or physical development, or the client would be at imminent risk of placement in a more restrictive environment. Assessment may include collection and review of available historical diagnostic data, provision or procurement of necessary tests and evaluations, and summarization of developmental levels and service needs and is conditional upon receipt of the release of information specified in subdivision (b). On and after July 1, ~~2003~~ 2004, the assessment shall be performed within 60 days following intake and if unusual circumstances prevent the completion of assessment within 60 days following intake, this assessment period may be extended by one 30-day period with the advance written approval of the department.

(b) In determining if an individual meets the definition of developmental disability contained in subdivision (a) of Section 4512, the regional center may consider evaluations and tests, including, but not limited to, intelligence tests, adaptive functioning tests, neurological and neuropsychological tests, diagnostic tests performed by a physician, psychiatric tests, and other tests or evaluations that have been performed by, and are available from, other sources.

SEC. 51. Section 4648.4 is added to the Welfare and Institutions Code, to read:

4648.4. (a) *The Legislature finds and declares that the state faces a fiscal crisis requiring that unprecedented measures be taken to reduce General Fund expenditures.*

(b) *Notwithstanding any other provision of law or regulation, during the 2003–04 fiscal year, no regional center may pay any provider of the following services or supports a rate that is greater than the rate that is in effect on or after June 30, 2003, unless the*

1 *increase is required by a contract between the regional center and*
2 *the vendor that is in effect on June 30, 2003, or the regional center*
3 *demonstrates that the approval is necessary to protect the*
4 *consumer's health or safety and the department has granted prior*
5 *written authorization:*

6 *(1) Supported living services.*

7 *(2) Transportation, including travel reimbursement.*

8 *(3) Socialization training programs.*

9 *(4) Behavior intervention training.*

10 *(5) Community integration training programs.*

11 *(6) Community activities support services.*

12 *(7) Mobile day programs.*

13 *(8) Creative art programs.*

14 *(9) Supplemental day services program supports.*

15 *(10) Adaptive skills trainers.*

16 *(11) Independent living specialists.*

17 *SEC. 52. Section 4681.5 is added to the Welfare and*
18 *Institutions Code, to read:*

19 *4681.5. (a) The Legislature finds and declares that the state*
20 *faces a fiscal crisis requiring that unprecedented measures be*
21 *taken to reduce General Fund expenditures.*

22 *(b) Notwithstanding any other provision of law or regulation,*
23 *during the 2003–04 fiscal year, no regional center may approve*
24 *any service level for a residential service provider, as defined in*
25 *Section 56005 of Title 17 of the California Code of Regulations,*
26 *if the approval would result in an increase in the rate to be paid to*
27 *the provider that is greater than the rate that is in effect on or after*
28 *June 30, 2003, unless the regional center demonstrates to the*
29 *department that the approval is necessary to protect the*
30 *consumer's health or safety and the department has granted prior*
31 *written authorization.*

32 *SEC. 53. Section 4685.5 of the Welfare and Institutions Code*
33 *is amended to read:*

34 *4685.5. (a) Notwithstanding any other provision of law,*
35 *commencing January 1, 1999, the department shall conduct a pilot*
36 *project under which funds shall be allocated for local*
37 *self-determination pilot programs that will enhance the ability of*
38 *a consumer and his or her family to control the decisions and*
39 *resources required to meet all or some of the objectives in his or*
40 *her individual program plan.*

(b) Local self-determination pilot programs funded pursuant to this section may include, but not be limited to, all of the following:

(1) Programs that provide for consumer and family control over which services best meet their needs and the objectives in the individual program plan.

(2) Programs that provide allowances or subsidies to consumers and their families.

(3) Programs providing for the use of debit cards.

(4) Programs that provide for the utilization of parent vendors, direct pay options, individual budgets for the procurement of services and supports, alternative case management, and vouchers.

(5) Wraparound programs.

~~(c) The department shall allocate funds for pilot programs in three~~ *allow the continuation of the existing pilot project in five* regional center catchment areas and shall, ~~to the extent possible, test a variety of mechanisms outlined in subdivision (b)~~ *expand the pilot project to other regional center catchment areas only when consistent with federal approval of a self-determination waiver. The department may approve additional regional center proposals to offer self-determination or self-directed services to consumers that meet criteria established by the department and that demonstrate purchase-of-services savings are achieved in the aggregate and have no impact on the General Fund.*

(d) Funds allocated to implement this section may be used for administrative and evaluation costs. Purchase-of-services costs shall be based on the estimated annual service costs associated with each participating consumer and family. Each proposal shall include a budget outlining administrative, service, and evaluation components.

(e) Pilot projects shall be conducted in the following regional center catchment areas:

(1) Tri-Counties Regional Center.

(2) Eastern Los Angeles Regional Center.

(3) Redwood Coast Regional Center.

(4) *Kern Regional Center.*

(5) *San Diego Regional Center.*

~~(f) If any of the regional centers specified in subdivision (e) do not submit a proposal meeting the requirements set forth in this section or by the department, the department may select another regional center to conduct a pilot project.~~

~~(g) The department shall develop and issue a request for proposals soliciting regional center participation in the pilot program. Consumers, families, regional centers, advocates, and service providers shall be consulted during the development of the request for proposal and selection of the pilot areas.~~

~~(h) Each pilot operating area receiving funding under this section shall demonstrate joint regional center and area board support for the local self-determination pilot program, and shall establish a local advisory committee, appointed jointly by the regional center and area board, made up of consumers, family members, advocates, and community leaders and that shall reflect the multicultural diversity and geographic profile of the catchment area. The local advisory committee shall review the development and ongoing progress of the local self-determination pilot program and may make ongoing recommendations for improvement to the regional center. By September 1, 2000, the local advisory committee shall submit to the department recommendations for the continuation and expansion of the program.~~

~~(i) The department shall issue a report to the Legislature no later than January 1, 2001, on the status of each pilot program funded by this section and recommendations with respect to continuation and expansion.~~

~~(j) Notwithstanding any other provision of law, as of January 1, 1999, of the balances available pursuant to Item 4300-490 of the Budget Act of 1998 for regional centers, the first seven hundred fifty thousand dollars (\$750,000) is reappropriated for the purposes of implementing this section, and shall be available for expenditure until January 1, 2002.~~

~~(k) This section shall remain in effect only until January 1, 2004, and as of that date is repealed, unless a later enacted statute, that becomes effective on or before January 1, 2004, extends or deletes that date.~~

SEC. 54. Section 4691.6 is added to the Welfare and Institutions Code, to read:

4691.6. (a) The Legislature finds and declares that the state faces a fiscal crisis requiring that unprecedented measures be taken to reduce General Fund expenditures.

(b) Notwithstanding any other provision of law or regulation, during the 2003-04 fiscal year, the department may not establish any permanent payment rate for a community-based day program

1 *or in-home respite service agency provider that has a temporary*
 2 *payment rate in effect on June 30, 2003, if the permanent payment*
 3 *rate would be greater than the temporary payment rate in effect on*
 4 *or after June 30, 2003, unless the regional center demonstrates to*
 5 *the department that the permanent payment rate is necessary to*
 6 *protect the consumers' health or safety.*

7 *(c) Notwithstanding any other provision of law or regulation,*
 8 *during the 2003–04 fiscal year, neither the department nor any*
 9 *regional center may approve any program design modification or*
 10 *revendorization for a community-based day program or in-home*
 11 *respite service agency provider that would result in an increase in*
 12 *the rate to be paid to the vendor from the rate that is in effect on*
 13 *or after June 30, 2003, unless the regional center demonstrates*
 14 *that the program design modification or revendorization is*
 15 *necessary to protect the consumers' health or safety and the*
 16 *department has granted prior written authorization.*

17 *(d) Notwithstanding any other provision of law or regulation,*
 18 *during the 2003–04 fiscal year, the department may not approve*
 19 *an anticipated rate adjusted for a community-based day program*
 20 *or in-home respite service agency provider that would result in an*
 21 *increase in the rate to be paid to the vendor from the rate that is*
 22 *in effect on or after June 30, 2003, unless the regional center*
 23 *demonstrates that the anticipated rate adjustment is necessary to*
 24 *protect the consumers' health or safety.*

25 *SEC. 55. Section 4781.5 of the Welfare and Institutions Code*
 26 *is amended to read:*

27 *4781.5. For the 2002–03 and 2003–04 fiscal year-years only,*
 28 *a regional center may not expend any purchase of service funds for*
 29 *the startup of any new program unless the expenditure is necessary*
 30 *to protect the consumer's health or safety or because of other*
 31 *extraordinary circumstances, and the department has granted prior*
 32 *written authorization for the expenditure. This provision shall not*
 33 *apply to any of the following:*

34 *(a) The purchase of services funds allocated as part of the*
 35 *department's community placement plan process.*

36 *(b) Expenditures for the startup of new programs made*
 37 *pursuant to a contract entered into before July 1, 2002.*

38 *SEC. 56. Section 5775 of the Welfare and Institutions Code is*
 39 *amended to read:*

1 5775. (a) Notwithstanding any other provision of state law,
2 the State Department of Mental Health shall implement managed
3 mental health care for Medi-Cal beneficiaries through
4 fee-for-service or capitated rate contracts with mental health plans,
5 including individual counties, counties acting jointly, any
6 qualified individual or organization, or a nongovernmental entity.
7 A contract may be exclusive and may be awarded on a geographic
8 basis.

9 (b) Two or more counties acting jointly may agree to deliver or
10 subcontract for the delivery of mental health services. The
11 agreement may encompass all or any portion of the mental health
12 services provided pursuant to this part. This agreement shall not
13 relieve the individual counties of financial responsibility for
14 providing these services. Any agreement between counties shall
15 delineate each county's responsibilities and fiscal liability.

16 (c) The department shall offer to contract with each county for
17 the delivery of mental health services to that county's Medi-Cal
18 beneficiary population prior to offering to contract with any other
19 entity, upon terms at least as favorable as any offered to a
20 noncounty contract provider. If a county elects not to contract with
21 the department, does not renew its contract, or does not meet the
22 minimum standards set by the department, the department may
23 elect to contract with any other governmental or nongovernmental
24 entity for the delivery of mental health services in that county and
25 may administer the delivery of mental health services until a
26 contract for a mental health plan is implemented. The county may
27 not subsequently contract to provide mental health services under
28 this part unless the department elects to contract with the county.

29 (d) If a county does not contract with the department to provide
30 mental health services, the county shall transfer the responsibility
31 for community Medi-Cal reimbursable mental health services and
32 the anticipated county matching funds needed for community
33 Medi-Cal mental health services in that county to the department.
34 The amount of the anticipated county matching funds shall be
35 determined by the department in consultation with the county, and
36 shall be adjusted annually. The amount transferred shall be based
37 on historical cost, adjusted for changes in the number of Medi-Cal
38 beneficiaries and other relevant factors. The anticipated county
39 matching funds shall be used by the department to contract with
40 another entity for mental health services, and shall not be expended

for any other purpose but the provision of those services and related administrative costs. The county shall continue to deliver non-Medi-Cal reimbursable mental health services in accordance with this division, and subject to subdivision (i) of Section 5777.

(e) ~~(4)~~ Whenever the department determines that a mental health plan has failed to comply with this part or any regulations adopted pursuant to this part that implement this part, the department may impose sanctions, including, but not limited to, fines, penalties, the withholding of payments, special requirements, probationary or corrective actions, or any other actions deemed necessary to prompt and ensure contract and performance compliance. If fines are imposed by the department, they may be withheld from the state matching funds provided to a mental health plan for Medi-Cal mental health services.

~~(2) The department shall adopt emergency regulations necessary to implement paragraph (1), including the establishment of procedures for the appeal of an administrative finding relative to paragraph (1), in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The initial adoption of emergency regulations pursuant to this paragraph shall be filed with the Office of Administrative Law during the 1997-98 Regular Session of the Legislature, and be deemed to be an emergency and necessary for the immediate preservation of the public peace, health, and safety, or general welfare, and shall be exempt from the review or approval of the Office of Administrative Law. Regulations adopted pursuant to this paragraph shall remain in effect for not more than 180 days. These regulations shall be developed in consultation with a statewide organization representing counties.~~

(f) *Notwithstanding any other provision of law, emergency regulations adopted pursuant to Section 14680 to implement the second phase of mental health managed care as provided in this part shall remain in effect until July 1, 2004, or until the regulations are made permanent, whichever occurs first, and shall not be subject to subdivision (g) of Section 11346.1 of the Government Code until that time.*

(g) The department may adopt emergency regulations necessary to implement ~~the payment systems in this part, Part 438 (commencing with Section 438.1) of Subpart A of Subchapter C of~~

1 *Chapter IV of Title 42 of the Code of Federal Regulations*, in
2 accordance with ~~the Administrative Procedure Act (Chapter~~
3 *Chapter 3.5* (commencing with Section 11340) of Part 1 of
4 Division 3 of Title 2 of the Government ~~Code~~) *Code*. The adoption
5 of emergency regulations to implement this part, that are filed with
6 the Office of Administrative Law within one year of the date on
7 which the act that amended this subdivision in ~~1997~~ 2003 took
8 effect, shall be deemed to be an emergency and necessary for the
9 immediate preservation of the public peace, health, and safety, or
10 general welfare, and shall remain in effect for no more than 180
11 days.

12 *SEC. 56.5. Section 14005.81 of the Welfare and Institutions*
13 *Code is amended to read:*

14 14005.81. (a) Effective October 1, 1998, in addition to the
15 two six-month periods of transitional Medi-Cal benefits provided
16 in Section 14005.8, the state shall fund and provide one additional
17 12-month period of transitional Medi-Cal to persons age 19 years
18 and older who have received 12 months of transitional Medi-Cal
19 under Section 14005.8 and who continue to meet the requirements
20 applicable to the additional six-month extension period provided
21 for in Section 14005.8, except that once a beneficiary has been
22 determined eligible for an additional 12 months of Medi-Cal
23 benefits under this section, the beneficiary shall not be required to
24 submit the status reports imposed by federal law. The benefits
25 provided under this section shall commence on the day following
26 the last day of receipt of benefits under Section 14005.8.

27 (b) In the case of an alien who has received 12 months of
28 transitional Medi-Cal under Section 14005.8, the benefits
29 provided under this section shall be limited to those benefits that
30 would be available to that person under Section 14005.8.

31 (c) It is the intent of the Legislature that the department seek a
32 mechanism for securing federal financial participation in
33 connection with pregnancy-related benefits provided under this
34 section.

35 (d) *The benefits described in this section shall become*
36 *unavailable on October 1, 2003. Individuals who are receiving*
37 *benefits under this section on September 30, 2003, shall be given*
38 *notice and the eligibility of that person shall be redetermined. The*
39 *department shall implement this subdivision by means of*

1 *all-county letters or similar instructions without the need for*
2 *adoption of regulations.*

3 *(e) This section shall become inoperative on October 1, 2003,*
4 *and, as of January 1, 2004, is repealed, unless a later enacted*
5 *statute that is enacted before January 1, 2004, deletes or extends*
6 *the dates on which it becomes inoperative and is repealed.*

7 *SEC. 57. Section 14011.7 of the Welfare and Institutions Code*
8 *is amended to read:*

9 14011.7. (a) To the extent allowed under federal law and only
10 if federal financial participation is available, the department shall
11 exercise the option provided in Section 1396r-1a of Title 42 of the
12 United States Code and the Managed Risk Medical Insurance
13 Board shall exercise the option provided in Section
14 1397gg(e)(1)(D) of Title 42 of the United States Code to
15 implement a program for preenrollment of children into the
16 Medi-Cal program or the Healthy Families Program. Upon the
17 exercise of both of the federal options described in this
18 subdivision, the department shall implement and administer a
19 program of preenrollment of children into the Medi-Cal program
20 or the Healthy Families Program.

21 (b) (1) Before July 1, 2003, the department shall develop an
22 electronic application to serve as the application for preenrollment
23 into the Medi-Cal program or the Healthy Families Program and
24 to also serve as an application for the Child Health and Disability
25 Prevention (CHDP) program, to the extent allowed under federal
26 law.

27 (2) *The department may, at its option, also use the electronic*
28 *application developed pursuant to paragraph (1), as a means to*
29 *enroll newborns into the Medi-Cal program as is authorized under*
30 *Section 1396a(e)(4) of Title 42 of the United States Code.*

31 (c) (1) The department may designate, as necessary, those
32 CHDP program providers described in paragraphs (1) to (5),
33 inclusive, of subdivision (g) of Section 124030 of the Health and
34 Safety Code as qualified entities who are authorized to determine
35 eligibility for the CHDP program and for preenrollment into either
36 the Medi-Cal program or the Healthy Families Program as
37 authorized under this section.

38 (2) The CHDP provider shall assist the parent or guardian of the
39 child seeking eligibility for the CHDP program and for

1 preenrollment into the Medi-Cal program or the Healthy Families
2 Program in completing the electronic application.

3 (d) The electronic application developed pursuant to
4 subdivision (b) may only be filed through the CHDP program
5 when the child is in need of CHDP program services in accordance
6 with the periodicity schedule used by the CHDP program.

7 (e) (1) The electronic application developed pursuant to
8 subdivision (b) shall request all information necessary for a CHDP
9 provider to make an immediate determination as to whether a child
10 meets the eligibility requirements for CHDP and for
11 preenrollment into either the Medi-Cal program or the Healthy
12 Families Program pursuant to the federal options described in
13 Section 1396r-1a or 1397gg(e)(1)(D) of Title 42 of the United
14 States Code.

15 (2) (A) If the electronic application indicates that the child is
16 seeking eligibility for either no cost full-scope Medi-Cal benefits
17 or enrollment in the Healthy Families Program, the department
18 shall mail to the child's parent or guardian a followup application
19 for Medi-Cal program eligibility or enrollment in the Healthy
20 Families Program. The parent or guardian of the child shall be
21 advised to complete and submit to the appropriate entity the
22 followup application.

23 (B) The followup application, at a minimum, shall include all
24 notices and forms necessary for both a Medi-Cal program and a
25 Healthy Families Program eligibility determination under state
26 and federal law, including, but not limited to, any information and
27 documentation that is required for the joint application package
28 described in Section 14011.1.

29 (C) The date of application for the Medi-Cal program or the
30 Healthy Families Program is the date the completed followup
31 application is submitted with the appropriate entity by the parent
32 or guardian.

33 (3) Upon making a determination pursuant to paragraph (1)
34 that a child is eligible, the CHDP provider shall inform the child's
35 parent or guardian of both of the following:

36 (A) That the child has been determined to be eligible for
37 services under the CHDP program and, if applicable, eligible for
38 preenrollment into either the Medi-Cal program or the Healthy
39 Families Program.

(B) That if the child has been determined to be eligible for preenrollment into either the Medi-Cal program or the Healthy Families Program, the period of preenrollment eligibility will end on the last day of the month following the month in which the determination of preenrollment eligibility is made, unless the parent or guardian completes and returns to the appropriate entity the followup application described in paragraph (2) on or before that date.

(4) If the followup application described in paragraph (2) is submitted on or before the last day of the month following the month in which a determination is made that the child is eligible for preenrollment into either the Medi-Cal program or the Healthy Families Program, the period of preenrollment eligibility shall continue until the completion of the determination process for the applicable program or programs.

(f) The scope and delivery of benefits provided to a child who is preenrolled for the Healthy Families Program pursuant to this section shall be identical to the scope and delivery of benefits received by a child who is preenrolled for the Medi-Cal program pursuant to this section.

(g) The department and the Managed Risk Medical Insurance Board shall seek approval of any amendments to the state plan, necessary to implement this section, for purposes of funding under Title XIX (42 U.S.C. 1396 et seq.) and Title XXI (42 U.S.C. 1397aa et seq.) of the Social Security Act. Notwithstanding any other provision of law and only when all necessary federal approvals have been obtained, this section shall be implemented only to the extent federal financial participation is available.

(h) Upon the implementation of this section, this section shall control in the event of a conflict with any provision of Article 6 (commencing with Section 124025) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code governing the Child Health and Disability Prevention program.

(i) To implement this section, the department may contract with public or private entities, or utilize existing health care service provider enrollment and payment mechanisms, including the Medi-Cal program's fiscal intermediary, only if services provided under the program are specifically identified and reimbursed in a manner that appropriately claims federal financial reimbursement. Contracts, including the Medi-Cal fiscal

1 intermediary contract for the Child Health and Disability
2 Prevention Program, including any contract amendment, any
3 system change pursuant to a change order, and any project or
4 systems development notice shall be exempt from Part 2
5 (commencing with Section 10100) of Division 2 of the Public
6 Contract Code, Chapter 7 (commencing with Section 11700) of
7 Part 1 of Division 3 of Title 2 of the Government Code, Section
8 19130 of the Government Code, and any policies, procedures, or
9 regulations authorized by these laws.

10 (j) Notwithstanding Chapter 3.5 (commencing with Section
11 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
12 the department shall implement this section by means of all-county
13 letters or similar instructions, without taking any further
14 regulatory action. Thereafter, the department shall adopt
15 regulations, as necessary, to implement this section in accordance
16 with the requirements of Chapter 3.5 (commencing with Section
17 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

18 (k) Notwithstanding subdivision (g), in no event shall this
19 section be implemented before April 1, 2003.

20 *SEC. 58. Section 14019.3 of the Welfare and Institutions Code*
21 *is amended to read:*

22 14019.3. (a) A beneficiary or any person on behalf of ~~the a~~
23 beneficiary who has paid for *medically necessary* health care
24 services, otherwise covered by the Medi-Cal program, received
25 by the beneficiary shall be entitled to a return from ~~the a~~ provider
26 *or directly from the department* of any part of the payment that
27 meets all of the following:

28 (1) Was rendered during ~~any~~ *the 90-day period prior to*
29 *application for, his or her Medi-Cal card, or after application for*
30 *but prior to the receipt issuance* of, his or her Medi-Cal card, for
31 which the card authorizes payment under Section 14018 or 14019,
32 *or was charged to the beneficiary as excess copayment during the*
33 *period after issuance of his or her Medi-Cal card.*

34 (2) ~~Was reimbursed to the provider by the Medi-Cal program;~~
35 ~~following all audits and appeals to which the provider is entitled.~~

36 (3) ~~Is not payable by a third party under contractual or other~~
37 ~~legal entitlement.~~

38 (4) ~~—~~

39 (3) Was not used to satisfy his or her paid or obligated liability
40 for health care services or to establish eligibility.

(b) To the extent permitted by federal law, whether or not a facility actually evicts a beneficiary, a beneficiary who may validly be evicted pursuant to Section 1439.7 of the Health and Safety Code, and who has received and paid for health care services otherwise covered by the Medi-Cal program shall not be entitled to the return from ~~the~~ *a* provider of any part of the payment for which service was rendered during any period prior to the date upon which knowledge is acquired by ~~the licensee~~ *a provider* of the application of ~~the~~ *a* beneficiary for Medi-Cal or the date of application for Medi-Cal, whichever is later.

(c) Upon presentation of the Medi-Cal card or other proof of eligibility, ~~the~~ *a* provider shall submit a Medi-Cal claim for reimbursement, subject to the rules and regulations of the Medi-Cal program.

(d) Notwithstanding subdivision (c), payment received from the state in accordance with Medi-Cal fee structures shall constitute payment in full, except that a provider, after making a full refund to the department of any Medi-Cal payments received for services, may recover all provider fees to the extent that any other contractual entitlement, including, but not limited to, a private group or indemnification insurance program, is obligated to pay the charges for the care provided ~~the~~ *a* beneficiary.

(e) ~~The~~ A provider shall return any and all payments made by ~~the~~ *a* beneficiary, or any person on behalf of ~~the~~ *a* beneficiary, other than a third party obligated to pay charges by reason of ~~the~~ *a* beneficiary's other contractual or legal entitlement for Medi-Cal program covered services upon receipt of Medi-Cal payment.

(f) To the extent permitted by federal law, the department shall waive overpayments made to a pharmacy provider that would otherwise be reimbursable to the department for prescription drugs returned to ~~the~~ *a* pharmacy provider from a nursing facility upon discontinuation of the drug therapy or death of ~~the~~ *a* beneficiary.

(g) *The department shall ensure payment to a beneficiary from a provider. A provider shall be notified in writing by the department when a beneficiary has submitted a claim to the department for reimbursement of services provided during the periods specified in paragraph (1) of subdivision (a). If a provider is not currently enrolled in the Medi-Cal program, the department shall assist in that enrollment. Enrollment in the Medi-Cal*

1 *program may be made retroactive to the date the service was*
2 *rendered.*

3 *(h) If a provider fails or refuses to reimburse a beneficiary for*
4 *services provided during the periods specified in paragraph (1) of*
5 *subdivision (a), within 90 days of receipt by the department of a*
6 *written request by a beneficiary or a representative of a*
7 *beneficiary, the department may take enforcement action that may*
8 *include, but shall not be limited to, any or all of the following:*

9 *(1) Withholding of future provider payments.*

10 *(2) Suspension of a provider from participation in the Medi-Cal*
11 *program.*

12 *(3) Recoupment of funds from a provider.*

13 *(i) If a provider fails or refuses to reimburse a beneficiary*
14 *within 90 days after receipt by the department of a written request*
15 *from a beneficiary or a representative of a beneficiary, the*
16 *department shall directly reimburse a beneficiary for medically*
17 *necessary health care expenses incurred during the periods*
18 *specified in paragraph (1) of subdivision (a). The department shall*
19 *reimburse a beneficiary only to the extent that federal financial*
20 *participation is available and only when the claim meets all of the*
21 *following criteria:*

22 *(1) The service was a covered benefit under the Medi-Cal*
23 *program.*

24 *(2) The provider was an enrolled Medi-Cal provider at the time*
25 *the service was rendered.*

26 *(3) The service was ordered by a health care provider, within*
27 *the scope of his or her practice.*

28 *(4) The beneficiary is eligible for reimbursement, as specified*
29 *in subdivision (a).*

30 *(5) The reimbursement shall be the amount paid by the*
31 *beneficiary, not to exceed the rate established for that service*
32 *under the Medi-Cal program.*

33 *(j) Notwithstanding Chapter 3.5 (commencing with Section*
34 *11340) of Part 1 of Division 3 of the Government Code, this section*
35 *may be implemented with a provider bulletin or similar*
36 *notification, without any further regulatory action.*

37 *SEC. 59. Section 14044 is added to the Welfare and*
38 *Institutions Code, to read:*

39 *14044. (a) The department may limit, for 18 months or less,*
40 *the American Medical Association's Current Procedural*

Terminology Fourth Edition (CPT-4) codes, the National Drug Codes (NDC), the Healthcare Common Procedure Coding System (HCPCS) codes, or codes established under Title II of the Health Insurance Portability & Accountability Act of 1996 (42 U.S.C. Sec. 1320d et seq.) for which any provider may bill, or for which reimbursement to any person or entity may be made by, the Medi-Cal program or other health care programs administered by the department if either of the following conditions exist:

(1) The department determines, by audit or other investigation, that excessive services or billings, or abuse, has occurred.

(2) The Medical Board of California or other licensing authority or a court of competent jurisdiction limits a licensee's practice of medicine or the rendering of health care, and the limitation precludes the licensee from performing services that could otherwise be reimbursed by the Medi-Cal program or other health care programs administered by the department.

(b) The department may impose a limitation pursuant to subdivision (a) for one or more codes or any combination of codes after giving the provider notice of the proposed limitation and, if applicable, the opportunity to appeal pursuant to subdivision (c).

(c) (1) A provider who receives notice of a proposed limitation based on paragraph (1) of subdivision (a) shall have 45 days from the date of notice to appeal the limitation by providing to the department reliable evidence that excessive services or billings, or abuse, did not occur.

(2) The department shall review the evidence and issue a decision within 45 days of receipt of the evidence.

(d) If a limitation is imposed pursuant to paragraph (1) of subdivision (a), it shall take effect on the 46th day after notice of the proposed limitation was given or, if the limitation is timely appealed, 15 days after the department gives the provider notice of its decision to impose the limitation. If a limitation is imposed pursuant to paragraph (2) of subdivision (a), it shall take effect 15 days after notice of the proposed limitation was given.

(e) If the department's limitation could interfere with the provider's or other prescriber's ability to provide health care services to a beneficiary, the burden to transfer a patient's care to another qualified person shall remain the responsibility of the licensee.

(f) For purposes of this section, the following definitions apply:

1 (1) “Abuse” has the same meaning as defined in Section
2 14043.1.

3 (2) “Administered by the department” means administered by
4 the department or its agents or contractors.

5 (3) “Excessive services or billings” means an amount that is
6 above normal within the provider or health care community based
7 on the data available to the department from any source, including
8 the department.

9 (4) “Licensee” means a person licensed under Division 2
10 (commencing with Section 500) of the Business and Professions
11 Code.

12 (5) “Other prescriber” means that person who is not the
13 primary or attending physician for a patient who is a beneficiary
14 of the Medi-Cal program or other health care program
15 administered by the department, and that person causes the
16 department, or its agents or contractors, to provide reimbursement
17 for a drug, device, medical service, or supply to the beneficiary.

18 (6) “Provider” has the same meaning as defined in Section
19 14043.1.

20 SEC. 60. Section 14087.101 is added to the Welfare and
21 Institutions Code, to read:

22 14087.101. For administrative costs incurred after January
23 1, 2004, the director may recover any administrative costs
24 incurred by a health plan authorized by this article deemed
25 excessive pursuant to Section 1300.78 of Title 28 of the California
26 Code of Regulations. Health plans that compensate their
27 subcontractors on a capitated basis shall comply with Section
28 1300.78 of Title 28 of the California Code of Regulations,
29 regarding administrative costs, considering the combined
30 administrative cost for the Medi-Cal business of the health plan
31 and its capitated subcontractors, that are Knox-Keene licensed
32 health care service plans. The recovery of excess administrative
33 cost shall be made in accordance with Sections 14087.103 and
34 14087.105.

35 SEC. 61. Section 14087.103 is added to the Welfare and
36 Institutions Code, to read:

37 14087.103. The department shall notify the health plan of the
38 director’s decision to seek recovery of excess administrative costs
39 pursuant to Section 14087.101 at least 30 days prior to initiating
40 the recovery process. The department may recover excess

1 administrative costs immediately after the 30-day notification
2 period, if the health plan does not file an appeal. A health plan may
3 dispute or appeal the director's decision in accordance with the
4 disputes section of the health plan's contract with the department
5 for services under this article. If a health plan elects to dispute or
6 appeal the director's decision, the director may recover any
7 administrative costs deemed excessive, but only after the health
8 plan has had the opportunity to exhaust all appeal procedures
9 provided for in the disputes section of the health plan's contract
10 with the department.

11 SEC. 62. Section 14087.105 is added to the Welfare and
12 Institutions Code, to read:

13 14087.105. When it has been determined that the director may
14 recover any administrative costs deemed excessive pursuant to
15 Section 14087.103, the director may recover any excess
16 administrative costs through an offset against any amount
17 currently due to the health plan under this chapter. The director
18 may also recover any administrative costs deemed excessive by
19 means of a repayment agreement executed between that health
20 plan and the director, and by any other means available at law.

21 SEC. 63. Section 14105.21 is added to the Welfare and
22 Institutions Code, to read:

23 14105.21. (a) An assistive device and sickroom supply dealer
24 may not bill the Medi-Cal program for prosthetic and orthotic
25 appliances.

26 (b) A pharmacy may not bill the Medi-Cal program for
27 prosthetic or orthotic appliances, unless the pharmacy is certified
28 by the National Community Pharmacists Association and only for
29 prosthetic and orthotic appliances that have been identified
30 pursuant to subdivision (c) or otherwise approved by the
31 department.

32 (c) The department shall establish a list of covered services and
33 maximum allowable reimbursement rates, subject to Section
34 14107.7, for prosthetic and orthotic appliances, and the list shall
35 be published in provider manuals.

36 (d) Reimbursement for prosthetic and orthotic appliances, as
37 defined in Section 51160 of Title 22 of the California Code of
38 Regulations, may not exceed 80 percent of the lowest maximum
39 allowance for California established by the federal Medicare
40 program for the same or similar services.

1 (e) *The department shall repeal Section 51515 of Title 22 of the*
2 *California Code of Regulations, as it read on the effective date of*
3 *the act adding this section.*

4 (f) *The department may implement this section by provider*
5 *manual or bulletin. Notwithstanding the provisions of the*
6 *Administrative Procedure Act, Chapter 3.5 (commencing with*
7 *Section 11340) of Part 1 of Division 3 of the Government Code,*
8 *actions under this section shall not be subject to the rulemaking*
9 *provisions of the Administrative Procedure Act or to the review and*
10 *approval of the Office of Administrative Law.*

11 SEC. 64. *Section 14105.22 is added to the Welfare and*
12 *Institutions Code, to read:*

13 14105.22. *Reimbursement for clinical laboratory or*
14 *laboratory services, as defined in Section 51137.2 of Title 22 of the*
15 *California Code of Regulations, may not exceed 80 percent of the*
16 *lowest maximum allowance established by the federal Medicare*
17 *program for the same or similar services.*

18 SEC. 65. *Section 14105.37 of the Welfare and Institutions*
19 *Code is amended to read:*

20 14105.37. (a) *The department shall notify each manufacturer*
21 *of drugs in therapeutic categories selected pursuant to Section*
22 *14105.33 of the provisions of Sections 14105.31 to 14105.42,*
23 *inclusive.*

24 (b) *If, within ~~45~~ 30 days of notification, a manufacturer does*
25 *not enter into negotiations for a contract pursuant to those sections,*
26 *the department may suspend or delete from the list of contract*
27 *drugs, or refuse to consider for addition, drugs of that*
28 *manufacturer in the selected therapeutic categories.*

29 (c) *If, after ~~150~~ 120 days from the initial notification, a contract*
30 *is not executed for a drug currently on the list of contract drugs,*
31 *the department may suspend or delete the drug from the list of*
32 *contract drugs.*

33 (d) *If, within ~~150~~ 120 days from the initial notification, a*
34 *contract is executed for a drug currently on the list of contract*
35 *drugs, the department shall retain the drug on the list of contract*
36 *drugs.*

37 (e) *If, within ~~150~~ 120 days from the date of the initial*
38 *notification, a contract is executed for a drug not currently on the*
39 *list of contract drugs, the department shall add the drug to the list*
40 *of contract drugs.*

(f) The department shall terminate all negotiations ~~150-120~~ days after the initial notification.

(g) The department may suspend or delete any drug from the list of contract drugs at the expiration of the contract term or when the contract between the department and the manufacturer of that drug is terminated.

(h) In the absence of a contract, the department may suspend or delete any drug from the list of contract drugs.

(i) Any drug suspended from the list of contract drugs pursuant to this section or Section 14105.35 shall be subject to prior authorization, as if that drug were not on the list of contract drugs.

(j) Any drug suspended from the list of contract drugs pursuant to this section or Section 14105.35 may be deleted from the list of contract drugs in accordance with Section 14105.38.

SEC. 66. Section 14105.395 is added to the Welfare and Institutions Code, to read:

14105.395. (a) The department may implement utilization controls through the establishment of guidelines, protocols, algorithms, or criteria for drugs, medical supplies, durable medical equipment, and enteral formulae. The department shall publish the guidelines, protocols, algorithms, or criteria in the pharmacy and medical provider manuals.

(b) The department shall issue providers written notice of changes pursuant to subdivision (a) at least 30 days prior to implementation.

(c) Changes made pursuant to this section are exempt from the requirements of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340), Chapter 4 (commencing with Section 11370), and Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code), and shall not be subject to the review and approval of the Office of Administrative Law. The department shall consult with interested parties and appropriate stakeholders in implementing this section with respect to all of the following:

(1) Notifying the provider representatives of the proposed change.

(2) Scheduling at least one meeting to discuss the change.

(3) Allowing for written input regarding the change.

(4) Providing advance notice on the implementation and effective date of the change.

1 SEC. 67. Section 14105.48 is added to the Welfare and
2 Institutions Code, to read:

3 14105.48. (a) The department shall establish a list of covered
4 services and maximum allowable reimbursement rates for durable
5 medical equipment as defined in Section 51160 of Title 22 of the
6 California Code of Regulations and the list shall be published in
7 provider manuals. The list shall specify utilization controls to be
8 applied to each type of durable medical equipment.

9 (b) Reimbursement for durable medical equipment, except
10 wheelchairs and wheelchair accessories, shall be the lesser of (1)
11 the amount billed pursuant to Section 51008.1 of Title 22 of the
12 California Code of Regulations, or (2) an amount that does not
13 exceed 80 percent of the lowest maximum allowance for California
14 established by the federal Medicare program for the same or
15 similar item or service, or (3) the guaranteed acquisition cost
16 negotiated by means of the contracting process provided for
17 pursuant to Section 14105.3 plus a percentage markup to be
18 established by the department.

19 (c) Reimbursement for wheelchairs and wheelchair
20 accessories shall be the lesser of (1) the amount billed pursuant to
21 Section 51008.1 of Title 22 of the California Code of Regulations,
22 or (2) an amount that does not exceed 100 percent of the lowest
23 maximum allowance for California established by the federal
24 Medicare program for the same or similar item or service, or (3)
25 the guaranteed acquisition cost negotiated by means of the
26 contracting process provided for pursuant to Section 14105.3 plus
27 a percentage markup to be established by the department.

28 (d) Reimbursement for all durable medical equipment billed to
29 the Medi-Cal program utilizing codes with no specified maximum
30 allowable rate shall be the lesser of (1) the amount billed pursuant
31 to Section 51008.1 of Title 22 of the California Code of
32 Regulations, or (2) the guaranteed acquisition cost negotiated by
33 means of the contracting process provided for pursuant to Section
34 14105.3 plus a percentage markup to be established by the
35 department, or (3) the actual acquisition cost plus a markup to be
36 established by the department, or (4) 80 percent of the
37 manufacturer's suggested retail purchase price, or (5) a price
38 established through targeted product-specific cost containment
39 provisions developed with providers.

1 (e) Reimbursement for all durable medical equipment supplies
2 and accessories billed to the Medi-Cal program shall be the lesser
3 of (1) the amount billed pursuant to Section 51008.1 of Title 22 of
4 the California Code of Regulations, or (2) the acquisition cost plus
5 a 23 percent markup.

6 (f) Any regulation in Division 3 of Title 22 of the California
7 Code of Regulations that contains provisions for reimbursement
8 rates for durable medical equipment shall be amended or repealed
9 effective for dates of service on or after the date of the act adding
10 this section.

11 (g) Notwithstanding Chapter 3.5 (commencing with Section
12 11340) of Part 1 of Division 3 of the Government Code, actions
13 under this section shall not be subject to the Administrative
14 Procedure Act or to the review and approval of the Office of
15 Administrative Law.

16 (h) The department shall consult with interested parties and
17 appropriate stakeholders in implementing this section with respect
18 to all of the following:

19 (1) Notifying the provider representatives of the proposed
20 change.

21 (2) Scheduling at least one meeting to discuss the change.

22 (3) Allowing for written input regarding the change.

23 (4) Providing advance notice on the implementation and
24 effective date of the change.

25 SEC. 68. Section 14105.86 is added to the Welfare and
26 Institutions Code, to read:

27 14105.86. (a) For the purposes of this section, the following
28 definitions apply:

29 (1) (A) "Average selling price" means the average unit price
30 charged by the manufacturer to wholesalers for drugs distributed
31 to the retail pharmacy class of trade, including sales to
32 wholesalers, pharmacies, physician offices, home health care
33 providers, nursing homes, pharmacy benefit managers, and
34 distributors.

35 (B) "Average selling price" excludes direct sales to hospitals,
36 health maintenance organizations, and wholesalers or
37 distributors when the drug is relabeled under the wholesaler's or
38 distributor's national drug code number. It also excludes prices
39 charged to the Indian Health Service, the Department of Veterans
40 Affairs, a state veteran's home receiving funds under Subchapter

1 V (commencing with Section 1741) of Title 38 of the United States
2 Code, the Department of Defense, the Public Health Service, or a
3 covered entity described in Section 340B(a)(4) of the United States
4 Public Health Service Act, any price charged under the federal
5 Supply Schedule of the General Services Administration, any
6 prices used under a state pharmaceutical assistance program, or
7 any depot prices and single award contract prices, as defined by
8 the secretary of any agency of the state or federal government.

9 (2) "Blood factors" means plasma protein therapies and their
10 recombinant analogs. Blood factors include, but are not limited to,
11 all of the following:

12 (A) Coagulation factors, including:

13 (i) Factor VIII, nonrecombinant.

14 (ii) Factor VIII, porcine.

15 (iii) Factor VIII, recombinant.

16 (iv) Factor IX, nonrecombinant.

17 (v) Factor IX, complex.

18 (vi) Factor IX, recombinant.

19 (vii) Antithrombin III.

20 (viii) Anti-inhibitor factor.

21 (ix) Von Willebrand factor.

22 (B) Immune Globulin Intravenous.

23 (C) Alpha-1 Proteinase Inhibitor.

24 (b) The reimbursement for blood factors shall be by national
25 drug code number and shall not exceed 120 percent of the average
26 selling price of the preceding quarter.

27 (c) The average selling price for blood factors of
28 manufacturers or distributors that do not report an average selling
29 price pursuant to subdivision (a) shall be identical to the average
30 manufacturer's price that the manufacturer or distributor reports
31 to the federal United States Centers for Medicare and Medicaid
32 Services. The reporting of an average selling price that does not
33 meet the requirement of this subdivision shall result in that blood
34 factor no longer being considered a covered benefit. This reporting
35 shall be done on the national drug code level.

36 (d) The average selling price shall be based on the criteria in
37 subdivision (a) and reported to the department on a quarterly
38 basis.

39 (e) Changes made to the list of covered blood factors under this
40 or any other section shall be exempt from the requirements of the

Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340), Chapter 4 (commencing with Section 11370), and Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code), and shall not be subject to the review and approval of the Office of Administrative Law.

SEC. 68.5. Section 14110.65 of the Welfare and Institutions Code is amended to read:

14110.65. (a) (1) The department shall, upon federal approval of a federal Medicaid State Plan amendment authorizing federal financial participation, provide a supplemental rate adjustment to the Medi-Cal reimbursement rate for specific nursing facilities, intermediate care facilities/developmentally disabled, intermediate care facilities/developmentally disabled-habilitative, intermediate care facilities/developmentally disabled-nursing, and pediatric subacute units that have a collectively bargained contract or a comparable, legally binding, written commitment to increase salaries, wages, or benefits for nonmanagerial, nonadministrative, noncontract staff. It is the intent of this section to make this supplemental rate adjustment available to both facilities with collective bargaining agreements and facilities without collective bargaining agreements that meet the requirements of this section. The supplemental rate adjustment shall be sufficient to fund the Medi-Cal portion of each facility's commitment that exceeds the labor cost adjustment for the covered employees that is already included in the Medi-Cal base reimbursement rate. Starting on the date of federal approval of the Medicaid State Plan amendment and at the start of each rate year thereafter, the supplemental rate adjustments made pursuant to this section shall occur for the commitments that increase salaries, wages, or benefits during the rate year as compared to the salaries, wages, or benefits paid in the preceding year. These supplemental rate adjustments shall be subject to certification of the availability of funds by the Department of Finance on May 15 of each year for the following fiscal year, and subject to the extent funds are appropriated for this purpose in the annual Budget Act. Authorization for the supplemental rate adjustments shall terminate on the date of implementation by the department of a Medi-Cal reimbursement system that uses facility-specific rates for nonhospital-based nursing facilities covered by this section.

(2) For a specific facility to be eligible for the supplemental rate adjustment, the facility shall submit the following to the department:

(A) Proof of a legally binding, written commitment to increase the salaries, wages, or benefits of existing and newly hired employees, excluding managers, administrators, and contract employees, during the rate year.

(B) Proof of the existence of a method of enforcement of the commitment, such as arbitration, that is available to the employees or their representative, and all of the following apply.

(i) It is expeditious.

(ii) It uses a neutral decisionmaker.

(iii) It is economical for the employees.

(C) Proof that the specific facility has provided written notice of the terms of the commitment and the availability of the enforcement mechanism to the relevant employees or their recognized representatives.

(3) For purposes of this section, a supplemental rate adjustment shall equal the Medi-Cal portion of the total amount of any increase in salaries, wages, and benefits provided in the enforceable written agreement minus any increase provided to that facility during that rate year provided in the standardized rate methodology (Medi-Cal base reimbursement rate) for labor related costs attributable to the employees covered by the commitment. Any supplemental rate adjustment made pursuant to this section shall only cover the period of the nonexpired, enforceable, written agreement. The department shall adjust the methodology for determining costs in the future rate determinations.

(4) Any supplemental rate adjustment for any facility under this section shall be no more than the greater of either of the following:

(A) Eight percent of that portion of the facility's per diem labor costs, prior to the rate year, attributable to employees covered by the commitment.

(B) Eight percent of the facility's peer group's per diem labor costs multiplied by the percentage of the facility's per diem labor costs attributable to employees covered by the commitment.

1 (5) The department shall terminate the adjustment for the
2 specific facility if it finds the binding written commitment has
3 expired and does not otherwise remain enforceable.

4 (6) The department may inspect relevant payroll and personnel
5 records of facilities receiving funds pursuant to this section in
6 order to ensure that the salary, wage, and benefit increases
7 provided for in this section have been implemented. In addition to
8 the remedies provided in subdivision (b), the department may
9 retroactively recover funds provided to a facility for labor costs
10 incurred after expiration of the commitment or due to the failure
11 of the facility to comply with the commitment.

12 (7) An employees enforcement or attempted enforcement of
13 the written commitment pursuant to paragraph (2) of subdivision
14 (a) shall not constitute a basis for adverse action against that
15 employee.

16 (b) The department shall provide instructions on facility
17 requirements by November 1, 2001, or at least 60 days before
18 implementation of this section, whichever is earlier. In developing
19 these instructions, the department shall consult with provider and
20 employee representatives. Audit, exit conference, and other
21 review protocol for determining facility compliance with this
22 section shall be developed by the department after consulting with
23 provider and employee representatives. Any facility that is paid
24 under the supplemental rate adjustment provided for in this section
25 that the director finds has not provided the salary, wage, and
26 benefit increases provided for shall be liable for the amount of
27 funds paid to the facility by this section but not distributed to
28 employees for salary, wage, and benefit increases, plus a penalty
29 equal to 10 percent of the funds not so distributed. Recoupment of
30 funds from any facility that disagrees with the findings of the
31 director specific to this section and has filed a request for hearing
32 pursuant to Section 14171, shall be deferred until the request for
33 hearing is either rejected or the director's final administrative
34 decision is rendered. Interest shall be applied to any recoupment
35 amount at the interest rate and timeframes specified in subdivision
36 (h) of Section 14171. The facility shall be subject to Section
37 14107.

38 (c) This section shall become inoperative on the effective date
39 of the act that added this subdivision, and, as of January 1, 2007,
40 is repealed, unless a later enacted statute that is enacted before

1 January 1, 2007, deletes or extends the dates on which it becomes
2 inoperative and is repealed.

3 *It is the intent of the Legislature that this section be implemented*
4 *immediately.*

5 (d) (1) *Solely for the period commencing February 1, 2002, to*
6 *July 31, 2004, inclusive, the department shall pay any*
7 *supplemental rate adjustment pursuant to subdivision (a) to the*
8 *extent that a facility submits a rate adjustment request to the*
9 *department within the period of time specified in this subdivision,*
10 *and where the department approves the supplemental rate*
11 *adjustment for the particular facility. Rate adjustment requests*
12 *shall be postmarked no later than 90 days after the department*
13 *mails the instructions described in subdivision (b) to the facilities.*

14 (2) *Notwithstanding Chapter 3.5 (commencing with Section*
15 *11340) of Part 1 of Division 3 of Title 2 of the Government Code,*
16 *the director may promulgate the instructions described in*
17 *subdivision (b) by means of a letter, notice, provider bulletin, or*
18 *other similar communication, without taking regulatory action.*

19 (3) *Notwithstanding any other provision of law, amounts*
20 *appropriated for purposes of this section in the Budget Act of 2003,*
21 *may be expended for supplemental rate adjustments relating to*
22 *periods in the 2002–03 fiscal year.*

23 (e) *This section shall become inoperative on August 1, 2004,*
24 *and, as of January 1, 2007, is repealed, unless a later enacted*
25 *statute that is enacted before January 1, 2007, deletes or extends*
26 *the dates on which it becomes inoperative and is repealed.*

27 SEC. 69. *Section 14124.79 of the Welfare and Institutions*
28 *Code is amended to read:*

29 14124.79. In the event that the beneficiary, his guardian,
30 conservator, personal representative, estate or survivors or any of
31 them brings an action against the third person who may be liable
32 for the injury, notice of institution of legal proceedings, notice of
33 settlement and all other notices required by this code shall be given
34 to the director in Sacramento except in cases where the director
35 specifies that notice shall be given to the Attorney General. All
36 such notices shall be given *by insurance carriers, as described in*
37 *Section 14124.70, having liability for the beneficiary's claim, and*
38 *by the attorney retained to assert the beneficiary's claim, or by the*
39 *injured party beneficiary, his guardian, conservator, personal*
40 *representative, estate or survivors, if no attorney is retained.*

SEC. 70. Section 14124.795 is added to the Welfare and Institutions Code, to read:

14124.795. It is the intent of the Legislature to comply with federal law requiring that when a beneficiary has other available health coverage or insurance, the Medi-Cal program shall be the payer of last resort. Notwithstanding any other provision of law, any carrier described in Section 14124.70, including automobile, casualty, property, and malpractice insurers, shall enter into an agreement with the department to permit and assist the matching of the department's Medi-Cal eligibility file against the carrier's claim files, utilizing, if necessary, social security numbers as common identifiers for the purpose of determining whether Medi-Cal benefits were provided to a beneficiary because of an injury for which another person is liable, or for which a carrier is liable in accordance with the provisions of any policy of insurance. The carrier shall maintain a centralized file of claimants' names, mailing addresses, and social security numbers or dates of birth. This information shall be made available to the department upon the department's reasonable request. The agreement described in this section shall include financial arrangements for reimbursing carriers for necessary costs incurred in furnishing requested information.

SEC. 71. Section 14132.27 is added to the Welfare and Institutions Code, to read:

14132.27. (a) (1) The department shall apply for a waiver of federal law pursuant to Section 1396n of Title 42 of the United States Code to test the efficacy of providing a disease management benefit to beneficiaries under the Medi-Cal program. A disease management benefit shall include, but not be limited to, the use of evidence-based practice guidelines, supporting adherence to care plans, and providing patient education, monitoring, and healthy lifestyle changes.

(2) The waiver developed pursuant to this section shall be known as the Disease Management Waiver. The department shall submit any necessary waiver applications or modifications to the Medicaid State Plan to the federal Centers for Medicare and Medicaid Services to implement the Disease Management Waiver, and shall implement the waiver only to the extent federal financial participation is available.

1 **(b)** *The Disease Management Waiver shall be designed to*
2 *provide eligible individuals with a range of services that enable*
3 *them to remain in the least restrictive and most homelike*
4 *environment while receiving the medical care necessary to protect*
5 *their health and well-being. Services provided pursuant to this*
6 *waiver program shall include only those not otherwise available*
7 *under the state plan, and may include, but are not limited to,*
8 *medication management, coordination with a primary care*
9 *provider; use of evidence-based practice guidelines, supporting*
10 *adherence to a plan of care, patient education, communication and*
11 *collaboration among providers, and process and outcome*
12 *measures. Coverage for those services shall be limited by the*
13 *terms, conditions, and duration of the federal waiver.*

14 **(c)** *Eligibility for the Disease Management Waiver shall be*
15 *limited to those persons who are eligible for the Medi-Cal program*
16 *as aged, blind, and disabled persons or those persons over 21*
17 *years of age who are not enrolled in a Medi-Cal managed care*
18 *plan, or eligible for the federal Medicare program, and who are*
19 *determined by the department to be at risk of, or diagnosed with,*
20 *select chronic diseases, including, but not limited to, advanced*
21 *atherosclerotic disease syndromes, congestive heart failure, and*
22 *diabetes. Eligibility shall be based on the individual's medical*
23 *diagnosis and prognosis, and other criteria, as specified in the*
24 *waiver.*

25 **(d)** *The Disease Management Waiver shall test the effectiveness*
26 *of providing a Medi-Cal disease management benefit. The*
27 *department shall evaluate the effectiveness of the Disease*
28 *Management Waiver.*

29 **(1)** *The evaluation shall include, but not be limited to,*
30 *participant satisfaction, health and safety, the quality of life of the*
31 *participant receiving the disease management benefit, and*
32 *demonstration of the cost neutrality of the Disease Management*
33 *Waiver as specified in federal guidelines.*

34 **(2)** *The evaluation shall estimate the projected savings, if any,*
35 *in the budgets of state and local governments if the Disease*
36 *Management Waiver was expanded statewide.*

37 **(3)** *The evaluation shall be submitted to the appropriate policy*
38 *and fiscal committees of the Legislature on or before January 1,*
39 *2008.*

1 (e) *The department shall limit the number of participants in the*
2 *Disease Management Waiver during the initial three years of its*
3 *operation to a number that will be statistically significant for*
4 *purposes of the waiver evaluation and that meets any requirements*
5 *of the federal government, including a request to waive statewide*
6 *implementation requirements for the waiver during the initial*
7 *years of evaluation.*

8 (f) *In undertaking this Disease Management Waiver, the*
9 *director may enter into contracts for the purpose of directly*
10 *providing Disease Management Waiver services.*

11 (g) *The department shall seek all federal waivers necessary to*
12 *allow for federal financial participation under this section.*

13 (h) *The Disease Management Waiver shall be developed and*
14 *implemented only to the extent that funds are appropriated or*
15 *otherwise available for that purpose.*

16 (i) *The department shall not implement this section if any of the*
17 *following apply:*

18 (1) *The department's application for federal funds under the*
19 *Disease Management Waiver is not accepted.*

20 (2) *Federal funding for the waiver ceases to be available.*

21 SEC. 71.5. *Section 14154 of the Welfare and Institutions Code*
22 *is amended to read:*

23 14154. (a) The department shall establish and maintain a
24 plan whereby costs for county administration of the determination
25 of eligibility for benefits under this chapter will be effectively
26 controlled within the amounts annually appropriated for that
27 administration. The plan, to be known as the County
28 Administrative Cost Control Plan, shall establish standards and
29 performance criteria, including workload, productivity, and
30 support services standards, to which counties shall adhere. The
31 plan shall include standards for controlling eligibility
32 determination costs that are incurred by performing eligibility
33 determinations at county hospitals, or that are incurred due to the
34 outstationing of any other eligibility function. Except as provided
35 in Section 14154.15, reimbursement to a county for outstationed
36 eligibility functions shall be based solely on productivity
37 standards applied to that county's welfare department office. The
38 plan shall be part of a single state plan, jointly developed by the
39 department and the State Department of Social Services, in
40 conjunction with the counties, for administrative cost control for

1 the ~~Aid to Families with Dependent Children (AFDC)~~, *California*
2 *Work Opportunity and Responsibility to Kids (CalWORKs)*, Food
3 Stamp, and Medical Assistance (Medi-Cal) programs. Allocations
4 shall be made to each county and shall be limited by and
5 determined based upon the County Administrative Cost Control
6 Plan. In administering the plan to control county administrative
7 costs, the department shall not allocate state funds to cover county
8 cost overruns that result from county failure to meet requirements
9 of the plan. The department and the State Department of Social
10 Services shall budget, administer, and allocate state funds for
11 county administration in a uniform and consistent manner.

12 (b) Nothing in this section, Section 15204.5, or Section 18906
13 shall be construed so as to limit the administrative or budgetary
14 responsibilities of the department in a manner that would violate
15 Section 14100.1, and thereby jeopardize federal financial
16 participation under the Medi-Cal program.

17 (c) The department is responsible for the Medi-Cal program in
18 accordance with state and federal law. A county shall determine
19 Medi-Cal eligibility in accordance with state and federal law. If in
20 the course of its duties the department becomes aware of accuracy
21 problems in any county, the department shall, within available
22 resources, provide training and technical assistance as appropriate.
23 Nothing in this section shall be interpreted to eliminate any remedy
24 otherwise available to the department to enforce accurate county
25 administration of the program. In administering the Medi-Cal
26 eligibility process, each county shall meet the following
27 performance standards each fiscal year:

28 (1) Complete eligibility determinations as follows:

29 (A) Ninety percent of the general applications without
30 applicant errors and are complete shall be completed within 45
31 days.

32 (B) Ninety percent of the applications for Medi-Cal based on
33 disability shall be completed within 90 days, excluding delays by
34 the state.

35 (2) (A) The department shall establish best-practice
36 guidelines for expedited enrollment of newborns into the
37 Medi-Cal program, preferably with the goal of enrolling newborns
38 within 10 days after the county is informed of the birth. The
39 department, in consultation with counties and other stakeholders,
40 shall work to develop a process for expediting enrollment for all

1 newborns, including those born to mothers receiving CalWORKs
2 assistance.

3 (B) Upon the development and implementation of the
4 best-practice guidelines and expedited processes, the department
5 and the counties may develop an expedited enrollment timeframe
6 for newborns that is separate from the standards for all other
7 applications, to the extent that the timeframe is consistent with
8 these guidelines and processes.

9 (C) Notwithstanding the rulemaking procedures of Chapter 3.5
10 (commencing with Section 11340) of Part 1 of Division 3 of Title
11 2 of the Government Code, the department may implement this
12 section by means of all-county letters or similar instructions,
13 without further regulatory action.

14 (3) Perform timely annual redeterminations, as follows:

15 (A) Ninety percent of the annual ~~redeterminations~~
16 ~~redetermination forms~~ shall be ~~commenced~~ *mailed to the recipient*
17 by the anniversary date.

18 (B) Ninety percent of the annual redeterminations shall be
19 completed within 60 days of the recipient's annual
20 redetermination date for those redeterminations based on forms
21 that are complete and have been returned to the county by the
22 recipient in a timely manner.

23 (C) Ninety percent of those annual redeterminations where the
24 redetermination form has not been returned to the county by the
25 recipient shall be completed by sending a notice of action to the
26 recipient within 45 days after the date the form was due to the
27 county.

28 (d) The department shall develop procedures in collaboration
29 with the counties and stakeholder groups for determining county
30 review cycles, sampling methodology and procedures, and data
31 reporting.

32 (e) On January 1 of each year, each applicable county, as
33 determined by the department, shall report to the department on
34 the county's results in meeting the performance standards
35 specified in this section. The report shall be subject to verification
36 by the department. County reports shall be provided to the public
37 upon written request.

38 (f) If the department finds that a county is not in compliance
39 with one or more of the standards set forth in this section, the
40 county shall, within 60 days, submit a corrective action plan to the

1 department for approval. The corrective action plan shall, at a
2 minimum, include steps that the county shall take to improve its
3 performance on the standard of standards with which the county
4 is out of compliance. The plan shall establish interim benchmarks
5 for improvement that shall be expected to be met by the county in
6 order to avoid a sanction.

7 (g) If a county does not meet the performance standards for
8 completing eligibility determinations and redeterminations as
9 specified in this section, the department may, at its sole discretion,
10 reduce the allocation of funds to that county in the following year
11 by 2 percent. Any funds so reduced may be restored by the
12 department if, in the determination of the department, sufficient
13 improvement has been made by the county in meeting the
14 performance standards during the year for which the funds were
15 reduced. If the county continues not to meet the performance
16 standards, the department may reduce the allocation by an
17 additional 2 percent for each year thereafter in which sufficient
18 improvement has not been made to meet the performance
19 standards.

20 *SEC. 72. Section 14159 is added to the Welfare and*
21 *Institutions Code, to read:*

22 *14159. Commencing with the 2004–05 fiscal year,*
23 *expenditures for Medi-Cal services and fiscal intermediary and*
24 *county administration costs included in the department's budget*
25 *shall be charged against the appropriation for the fiscal year in*
26 *which the billing is paid. Commencing July 1, 2004, all 2002–03*
27 *fiscal year and prior accrued obligations of the Health Care*
28 *Deposit Fund shall become obligations of the 2004–05 fiscal year*
29 *and all moneys available from the 2002–03 fiscal year and prior*
30 *appropriations shall be reappropriated to the 2004–05 fiscal year*
31 *for that purpose.*

32 *SEC. 73. Article 5.5 (commencing with Section 14464.5) is*
33 *added to Chapter 8 of Part 3 of Division 9 of the Welfare and*
34 *Institutions Code, to read:*

35
36 *Article 5.5. Quality Improvement Fee for Medi-Cal Managed*
37 *Care Plans*
38

39 *14464.5. (a) For purposes of this article, the following*
40 *definitions apply:*

1 (1) “Capitation payment” means the monthly amount paid by
2 the state to a designated Medi-Cal managed care plan in exchange
3 for contracted health care services procured by means of the
4 Medi-Cal managed care contracts set forth in paragraph (3).

5 (2) “Capitation rate” means the per member per month rate
6 used to calculate the capitation payments.

7 (3) “Medi-Cal managed care plan” means any Medi-Cal
8 managed care plan contracting with the department to provide
9 services to enrolled Medi-Cal beneficiaries pursuant to Chapter 7
10 (commencing with Section 14000), this chapter, or Chapter 8.75
11 (commencing with Section 14590), and that is also an organization
12 that meets the criteria to contract for services in Section 1396b(m)
13 of Title 42 of the United States Code.

14 (b) The department may impose, on an annual basis, a quality
15 improvement fee on the capitation payments paid to Medi-Cal
16 managed care plans for enrolled Medi-Cal beneficiaries. The
17 quality improvement fee shall be paid to the state monthly and
18 shall be a percentage as determined pursuant to paragraph (1)
19 multiplied by each Medi-Cal managed care plan’s capitation
20 payments. The quality improvement fee shall be subject to all of the
21 following provisions:

22 (1) The department shall determine the quality improvement
23 percentage, not to exceed 6 percent of the capitation payments and
24 shall notify the Medi-Cal managed care plans of that
25 determination.

26 (2) The quality improvement fee shall be paid to the state within
27 15 calendar days following notification by the department of the
28 amount due.

29 (3) The quality improvement fee shall be deposited in the
30 General Fund.

31 (4) If the Medi-Cal managed care plan does not timely pay the
32 quality improvement fee, or any part thereof, the department may
33 offset the amount of the fee that is unpaid against any amounts due
34 from the state to the Medi-Cal managed care plan.
35 Notwithstanding any such offset, the methodology for determining
36 the fee as set forth in this subdivision shall be followed.

37 (5) The department shall make retrospective adjustments as
38 necessary to the amounts calculated pursuant to this subdivision
39 in order to assure that the Medi-Cal managed care plan’s
40 aggregate quality improvement fee for any particular state fiscal

1 year does not exceed 6 percent of the aggregate annual capitation
2 payments paid to the Medi-Cal managed care plan for that year.

3 (c) (1) The department shall implement this section in a
4 manner that complies with federal requirements. If the department
5 is unable to comply with the federal requirements for federal
6 matching funds under this section or is unable to use the 2002–03
7 fiscal year level of support for federal matching dollars other than
8 for a change in covered benefits or covered populations required
9 under the state’s Medi-Cal contract with health care service plans,
10 the quality improvement fee shall no longer be assessed or
11 collected.

12 (2) In all fiscal years governed by this section, Medi-Cal
13 capitation rates shall not be reduced as a direct result of the quality
14 improvement fee assessed under this section. This subdivision does
15 not apply to a change in Medi-Cal capitation rates caused by a
16 change in actuarial factors, including covered benefits, covered
17 populations, or Medi-Cal provider reimbursement, under the
18 state’s Medi-Cal contract with health care service plans.

19 (d) The director, or his or her designee, shall administer this
20 section.

21 (e) The director may adopt regulations as are necessary to
22 implement this section. These regulations shall be adopted as
23 emergency regulations in accordance with the rulemaking
24 provisions of the Administrative Procedure Act (Chapter 3.5
25 (commencing with Section 11340) of Part 1 of Division 3 of Title
26 2 of the Government Code). For purposes of this section, the
27 adoption of regulations shall be deemed an emergency and
28 necessary for the immediate preservation of the public peace,
29 health, and safety or general welfare. The regulations shall
30 include, but not be limited to, any regulations necessary for either
31 of the following purposes:

32 (1) The administration of this section, including the proper
33 imposition and collection of the quality improvement fees and
34 associated penalties.

35 (2) The development of any forms necessary to calculate,
36 notify, collect, and distribute the quality improvement fees.

37 (f) As an alternative to subdivision (e), and notwithstanding
38 Chapter 3.5 (commencing with Section 11340) of Part 1 of
39 Division 3 of Title 2 of the Government Code, the director may
40 implement this section by means of a provider bulletin, contract

1 *amendment, policy letter, or other similar instructions, without*
2 *taking regulatory action.*

3 *(g) This section shall not apply to either of the following:*

4 *(1) State supported services contracts separately entered into*
5 *with Medi-Cal managed care plans to cover only those services*
6 *that are expressly set forth in those contracts, are paid for solely*
7 *with state funds, and are unavailable for federal financial*
8 *participation.*

9 *(2) Payments derived from intergovernmental transfers and*
10 *associated federal financial participation.*

11 *(h) Any limitation on rates or payments to the Medi-Cal*
12 *managed care plan based on Medi-Cal fee-for-service costs shall*
13 *be increased to include any capitation rate increase related to the*
14 *quality improvement fee in subdivision (b).*

15 *(i) To the extent necessary to comply with federal requirements*
16 *pursuant to paragraph (2) of subdivision (c), the director may*
17 *deviate from the provisions of this section with respect to either or*
18 *both of the following:*

19 *(1) The methodology for calculating or imposing the quality*
20 *improvement fee pursuant to subdivision (b).*

21 *(2) The exclusions specified in subdivision (g).*

22 *(j) Notwithstanding any other provision of this section, the*
23 *department may not impose a quality improvement fee on any*
24 *payment to be made to Medi-Cal managed care plans, other than*
25 *the capitated payments as defined in paragraph (1) of subdivision*
26 *(a).*

27 *(k) The department shall commence collecting the quality*
28 *improvement fees pursuant to subdivision (b) no sooner than*
29 *January 1, 2004.*

30 *SEC. 74. Section 14684.1 is added to the Welfare and*
31 *Institutions Code, to read:*

32 *14684.1. (a) The State Department of Mental Health shall*
33 *establish a process for second level treatment authorization*
34 *request appeals to review and resolve disputes between mental*
35 *health plans and hospitals.*

36 *(b) When the department establishes an appeals process, the*
37 *department shall comply with all of the following:*

38 *(1) The department shall review appeals initiated by hospitals*
39 *and render decisions on appeals based on findings that are the*

1 result of a review of supporting documents submitted by mental
2 health plans and hospitals.

3 (2) If the department upholds a mental health plan denial of
4 payment of a hospital claim, a review fee shall be assessed on the
5 provider.

6 (3) If the State Department of Mental Health reverses a mental
7 health plan denial of payment of a hospital claim, a review fee shall
8 be assessed on the mental health plan.

9 (4) If the department decision regarding a mental health plan
10 denial of payment upholds the claim in part and reverses the claim
11 in part, the department shall prorate the review fee between the
12 parties accordingly.

13 (c) The amount of the review fees shall be calculated and
14 adjusted annually. The methodology and calculation used to
15 determine the fee amounts shall result in an aggregate fee amount
16 that, in conjunction with any other outside source of funding for
17 this function, may not exceed the aggregate annual costs of
18 providing second level treatment authorization request reviews.

19 (d) Fees collected by the department shall be retained by the
20 department and used to offset administrative and personnel
21 services costs associated with the appeals process.

22 (e) The department may use the fees collected, in conjunction
23 with other available appropriate funding for this function, to
24 contract for the performance of the appeals process function.

25 SEC. 75. Section 16809 of the Welfare and Institutions Code,
26 as amended by Section 90 of Chapter 1161 of the Statutes of 2002,
27 is amended to read:

28 16809. (a) (1) The board of supervisors of a county that
29 contracted with the department pursuant to Section 16709 during
30 the 1990–91 fiscal year and any county with a population under
31 300,000, as determined in accordance with the 1990 decennial
32 census, by adopting a resolution to that effect, may elect to
33 participate in the County Medical Services Program. The County
34 Medical Services Program shall have responsibilities for specified
35 health services to county residents certified eligible for those
36 services by the county.

37 (2) If the County Medical Services Program Governing Board
38 contracts with the department to administer the County Medical
39 Services Program, that contract shall include, but need not be
40 limited to, all of the following:



1 (A) Provisions for the payment to participating counties for
2 making eligibility determinations based on the formula used by the
3 County Medical Services Program for the 1993–94 fiscal year.

4 (B) Provisions for payment of expenses of the County Medical
5 Services Program Governing Board.

6 (C) Provisions relating to the flow of funds from counties’
7 vehicle license fees, sales taxes, and participation fees and the
8 procedures to be followed if a county does not pay those funds to
9 the program.

10 (D) Those provisions, as applicable, contained in the 1993–94
11 fiscal year contract with counties under the County Medical
12 Services Program.

13 (3) The contract between the department and the County
14 Medical Services Program Governing Board shall require that the
15 County Medical Services Program Governing Board shall
16 reimburse three million five hundred thousand dollars
17 (\$3,500,000) for the state costs of providing administrative
18 support to the County Medical Services Program. The department
19 may decline to implement decisions made by the governing board
20 that would require a greater level of administrative support than
21 that for the 1993–94 fiscal year. The department may implement
22 decisions upon compensation by the governing board to cover that
23 increased level of support.

24 (4) The contract between the department and the County
25 Medical Services Program Governing Board may include
26 provisions for the administration of a pharmacy benefit program
27 and, pursuant to these provisions, the department may negotiate,
28 on behalf of the County Medical Services Program, rebates from
29 manufacturers that agree to participate. The governing board shall
30 reimburse the department for staff costs associated with this
31 paragraph.

32 (5) The department shall administer the County Medical
33 Services Program pursuant to the provisions of the 1993–94 fiscal
34 year contract with the counties and regulations relating to the
35 administration of the program until the County Medical Services
36 Program Governing Board executes a contract for the
37 administration of the County Medical Services Program and
38 adopts regulations for that purpose.

39 (6) The department shall not be liable for any costs related to
40 decisions of the County Medical Services Program Governing

1 Board that are in excess of those set forth in the contract between
2 the department and the County Medical Services Program
3 Governing Board.

4 (b) Each county intending to participate in the County Medical
5 Services Program pursuant to this section shall submit to the
6 Governing Board of the County Medical Services Program a
7 notice of intent to contract adopted by the board of supervisors no
8 later than April 1 of the fiscal year preceding the fiscal year in
9 which the county will participate in the County Medical Services
10 Program.

11 (c) A county participating in the County Medical Services
12 Program pursuant to this section shall not be relieved of its
13 indigent health care obligation under Section 17000.

14 (d) (1) The County Medical Services Program Account is
15 established in the County Health Services Fund. The County
16 Medical Services Program Account is continuously appropriated,
17 notwithstanding Section 13340 of the Government Code, without
18 regard to fiscal years. The following amounts may be deposited in
19 the account:

20 (A) Any interest earned upon money deposited in the account.

21 (B) Moneys provided by participating counties or appropriated
22 by the Legislature to the account.

23 (C) Moneys loaned pursuant to subdivision (q).

24 (2) The methods and procedures used to deposit funds into the
25 account shall be consistent with the methods used by the program
26 during the 1993–94 fiscal year.

27 (e) Moneys in the program account shall be used by the
28 department, pursuant to its contract with the County Medical
29 Services Program Governing Board, to pay for health care services
30 provided to the persons meeting the eligibility criteria established
31 pursuant to subdivision (j) and to pay for the expense of the
32 governing board as set forth in the contract between the board and
33 the department. In addition, moneys in this account may be used
34 to reimburse the department for state costs pursuant to paragraph
35 (3) of subdivision (a).

36 (f) (1) Moneys in this account shall be administered on an
37 accrual basis and notwithstanding any other provision of law,
38 except as provided in this section, shall not be transferred to any
39 other fund or account in the State Treasury except for purposes of
40 investment as provided in Article 4 (commencing with Section



1 16470) of Chapter 3 of Part 2 of Division 4 of Title 2 of the
2 Government Code.

3 (2) (A) All interest or other increment resulting from the
4 investment shall be deposited in the program account, at the end
5 of the 1982–83 fiscal year and every six months thereafter,
6 notwithstanding Section 16305.7 of the Government Code.

7 (B) All interest deposited pursuant to subparagraph (A) shall be
8 available to reimburse program-covered services, County Medical
9 Services Program Governing Board expenses, or for expenditures
10 to augment the program's rates, benefits, or eligibility criteria
11 pursuant to subdivision (j).

12 (g) A separate County Medical Services Program Reserve
13 Account is established in the County Health Services Fund. Six
14 months after the end of each fiscal year, any projected savings in
15 the program account shall be transferred to the reserve account,
16 with final settlement occurring no more than 12 months later.
17 Moneys in this account shall be utilized when expenditures for
18 health services made pursuant to subdivision (j) for a fiscal year
19 exceed the amount of funds available in the program account for
20 that fiscal year. When funds in the reserve account are estimated
21 to exceed 10 percent of the budget for health services for all
22 counties electing to participate in the County Medical Services
23 Program under this section for the fiscal year, the additional funds
24 shall be available for expenditure to augment the rates, benefits,
25 or eligibility criteria pursuant to subdivision (j) or for reducing the
26 participation fees as determined by the County Medical Services
27 Program Governing Board pursuant to subdivision (i). Nothing in
28 this section shall preclude the CMSP Governing Board from
29 establishing other reserves.

30 (h) Moneys in the program account and the reserve account,
31 except for moneys provided by the state in excess of the amount
32 required to fund the state risk specified in subdivision (j), and any
33 funds loaned pursuant to subdivision (q) shall not be transferred
34 to any other fund or account in the State Treasury except for
35 purposes of investment as provided in Article 4 (commencing with
36 Section 16470) of Chapter 3 of Part 2 of Division 4 of Title 2 of
37 the Government Code. All interest or other increment resulting
38 from investment shall be deposited in the program account,
39 notwithstanding Section 16705.7 of the Government Code.

1 (i) (1) Counties shall pay participation fees as established by
2 the County Medical Services Program Governing Board and their
3 jurisdictional risk amount in a method that is consistent with that
4 established in the 1993–94 fiscal year.

5 (2) A county may request, due to financial hardship, the
6 payments under paragraph (1) be delayed. The request shall be
7 subject to approval by the CMSP Governing Board.

8 (3) Payments made pursuant to this subdivision shall be
9 deposited in the program account.

10 (4) Payments may be made as part of the deposits authorized by
11 the county pursuant to Sections 17603.05 and 17604.05.

12 (j) (1) (A) For the 1991–92 fiscal year and all preceding fiscal
13 years, the state shall be at risk for any costs in excess of the amounts
14 deposited in the reserve fund.

15 (B) (i) Beginning in the 1992–93 fiscal year and for each fiscal
16 year thereafter, counties and the state shall share the risk for cost
17 increases of the County Medical Services Program not funded
18 through other sources. The state shall be at risk for any cost that
19 exceeds the cumulative annual growth in dedicated sales tax and
20 vehicle license fee revenue, up to the amount of twenty million two
21 hundred thirty-seven thousand four hundred sixty dollars
22 (\$20,237,460) per fiscal year, except for the 1999–2000, 2000–01,
23 2001–02, ~~and~~ 2002–03, *and* 2003–04 fiscal years. Counties shall
24 be at risk up to the cumulative annual growth in the Local Revenue
25 Fund created by Section 17600, according to the table specified in
26 paragraph (2), to the County Medical Services Program, plus the
27 additional cost increases in excess of twenty million two hundred
28 thirty-seven thousand four hundred sixty dollars (\$20,237,460)
29 per fiscal year, except for the 1999–2000, 2000–01, 2001–02, ~~and~~
30 2002–03, *and* 2003–04 fiscal years. In the 1994–95 fiscal year, the
31 amount of the state risk shall be twenty million two hundred
32 thirty-seven thousand four hundred sixty dollars (\$20,237,460)
33 per fiscal year, in addition to the cost of administrative support
34 pursuant to paragraph (3) of subdivision (a).

35 (ii) For the 1999–2000, 2000–01, 2001–02, ~~and~~ 2002–03, *and*
36 2003–04 fiscal years, the state shall not be at risk for any cost that
37 exceeds the cumulative annual growth in dedicated sales tax and
38 vehicle license fee revenue. Counties shall be at risk up to the
39 cumulative annual growth in the Local Revenue Fund created by
40 Section 17600, according to the table specified in paragraph (2),

to the County Medical Services Program, plus any additional cost increases for the 1999–2000, 2000–01, 2001–02, ~~and~~ 2002–03, and 2003–04 fiscal years.

(C) The CMSP Governing Board, after consultation with the department, shall establish uniform eligibility criteria and benefits for the County Medical Services Program.

(2) For the 1991–92 fiscal year, jurisdictional risk limitations shall be as follows:

Jurisdiction	Amount
Alpine	\$ 13,150
Amador	620,264
Butte	5,950,593
Calaveras	913,959
Colusa	799,988
Del Norte	781,358
El Dorado	3,535,288
Glenn	787,933
Humboldt	6,883,182
Imperial	6,394,422
Inyo	1,100,257
Kings	2,832,833
Lassen	687,113
Madera	2,882,147
Marin	7,725,909
Mariposa	435,062
Modoc	469,034
Mono	369,309
Napa	3,062,967
Nevada	1,860,793
Plumas	905,192
San Benito	1,086,011
Shasta	5,361,013
Sierra	135,888
Siskiyou	1,372,034
Solano	6,871,127
Sonoma	13,183,359
Sutter	2,996,118
Tehama	1,912,299
Trinity	611,497

1	Tuolumne	1,455,320
2	Yuba	2,395,580

3

4 (3) Beginning in the 1991–92 fiscal year and in subsequent
5 fiscal years, the jurisdictional risk limitation for the counties that
6 did not contract with the department pursuant to Section 16709
7 during the 1990–91 fiscal year shall be the amount specified in
8 paragraph (A) plus the amount determined pursuant to paragraph
9 (B), minus the amount specified by the County Medical Services
10 Program Governing Board as participation fees.

11 (A)

12

13	Jurisdiction	Amount
14	Lake	\$1,022,963
15	Mendocino	1,654,999
16	Merced	2,033,729
17	Placer	1,338,330
18	San Luis Obispo	2,000,491
19	Santa Cruz	3,037,783
20	Yolo	1,475,620

21

22 (B) The amount of funds necessary to fully fund the anticipated
23 costs for the county shall be determined by the CMSP Governing
24 Board before a county is permitted to participate in the County
25 Medical Services Program.

26 (4) For the 1994–95 and 1995–96 fiscal years, the specific
27 amounts and method of apportioning risk to each participating
28 county may be adjusted by the CMSP Governing Board.

29 (k) The Legislature hereby determines that an expedited
30 contract process for contracts under this section is necessary.
31 Contracts under this section shall be exempt from Part 2
32 (commencing with Section 10100) of Division 2 of the Public
33 Contract Code. Contracts of the department pursuant to this
34 section shall have no force or effect unless they are approved by
35 the Department of Finance.

36 (l) The state shall not incur any liability except as specified in
37 this section.

38 (m) Third-party recoveries for services provided under this
39 section pursuant to Article 3.5 (commencing with Section
40 14124.70) of Chapter 7 of Part 3 may be pursued.



1 (n) Under the program provided for in this section, the
2 department may reimburse hospitals for inpatient services at the
3 rates negotiated for the Medi-Cal program by the California
4 Medical Assistance Commission, pursuant to Article 2.6
5 (commencing with Section 14081) of Chapter 7 of Part 3, if the
6 California Medical Assistance Commission determines that
7 reimbursement to the hospital at the contracted rate will not have
8 a detrimental fiscal impact on either the Medi-Cal program or the
9 program provided for in this section. In negotiating and
10 renegotiating contracts with hospitals, the commission may seek
11 terms which allow reimbursement for patients receiving services
12 under this section at contracted Medi-Cal rates.

13 (o) Any hospital which has a contract with the state for
14 inpatient services under the Medi-Cal program and which has been
15 approved by the commission to be reimbursed for patients
16 receiving services under this section shall not deny services to
17 these patients.

18 (p) Participating counties may conduct an independent
19 program review to identify ways through which program savings
20 may be generated. The counties and the department may
21 collectively pursue identified options for the realization of
22 program savings.

23 (q) The Department of Finance may authorize a loan of up to
24 thirty million dollars (\$30,000,000) for deposit into the program
25 account to ensure that there are sufficient funds available to
26 reimburse providers and counties pursuant to this section.

27 (r) Regulations adopted by the department pursuant to this
28 section shall remain operative and shall be used to operate the
29 County Medical Services Program until a contract with the County
30 Medical Services Program Governing Board is executed and
31 regulations, as appropriate, are adopted by the County Medical
32 Services Program Governing Board. Notwithstanding Chapter 3.5
33 (commencing with Section 11340) of Part 1 of Division 3 of Title
34 2 of the Government Code, those regulations adopted under the
35 County Medical Services Program shall become inoperative until
36 January 1, 1998, except those regulations that the department, in
37 consultation with the County Medical Services Program
38 Governing Board, determines are needed to continue to administer
39 the County Medical Services Program. The department shall
40 notify the Office of Administrative Law as to those regulations the

1 department will continue to use in the implementation of the
2 County Medical Services Program.

3 (s) Moneys appropriated from the General Fund to meet the
4 state risk as set forth in subparagraph (B) of paragraph (1) of
5 subdivision (j) shall not be available for those counties electing to
6 disenroll from the County Medical Services Program.

7 (t) This section shall remain in effect only until January 1,
8 2008, and as of that date is repealed, unless a later enacted statute,
9 that is enacted on or before January 1, 2008, deletes or extends that
10 date.

11 *SEC. 75.5. Section 13 of Chapter 9 of the Statutes of the First*
12 *Extraordinary Session of 2003 is repealed.*

13 ~~Sec. 13. (a) Due to the large State Budget deficit projected for~~
14 ~~the 2003–04 fiscal year, and in order to implement changes in the~~
15 ~~level of funding for health care services, it is the intent of the~~
16 ~~Legislature in repealing Section 14110.65 of the Welfare and~~
17 ~~Institutions Code in Section 9 of this act that no further~~
18 ~~supplemental rate adjustments be paid to long-term care facilities~~
19 ~~pursuant to Section 14110.65 of the Welfare and Institutions Code.~~

20 ~~(b) After the effective date of this act, the State Department of~~
21 ~~Health Services shall not pay any supplemental rate adjustment~~
22 ~~pursuant to subdivision (a) of Section 14110.65 of the Welfare and~~
23 ~~Institutions Code, except as provided in subdivision (c).~~

24 ~~(c) Solely for the period beginning February 1, 2002, to~~
25 ~~December 31, 2002, inclusive, the State Department of Health~~
26 ~~Services shall continue to pay any supplemental rate adjustment~~
27 ~~pursuant to subdivision (a) of Section 14110.65 of the Welfare and~~
28 ~~Institutions Code to the extent that the department had, on or~~
29 ~~before December 31, 2002, approved that supplemental rate~~
30 ~~adjustment for that period.~~

31 *SEC. 76. (a) Of the amount appropriated in Item*
32 *4260-111-0001 of the Budget Act of 2003 from the Cigarette and*
33 *Tobacco Products Surtax Fund, twenty-four million eight hundred*
34 *three thousand dollars (\$24,803,000) shall be allocated in*
35 *accordance with subdivision (b) for the 2003–04 fiscal year from*
36 *the following accounts:*

37 *(1) Nine million fifteen thousand dollars (\$9,015,000) from the*
38 *Hospital Services Account.*

39 *(2) Two million three hundred twenty-eight thousand dollars*
40 *(\$2,328,000) from the Physician Services Account.*

1 (3) *Thirteen million four hundred sixty thousand dollars*
2 *(\$13,460,000) from the Unallocated Account.*

3 (b) *The funds specified in subdivision (a) shall be allocated*
4 *proportionately as follows:*

5 (1) *Twenty-two million three hundred twenty-four thousand*
6 *dollars (\$22,324,000) shall be administered and allocated for*
7 *distribution through the California Healthcare for Indigents*
8 *Program (CHIP), Chapter 5 (commencing with Section 16940) of*
9 *Part 4.7 of Division 9 of the Welfare and Institutions Code.*

10 (2) *Two million four hundred seventy-nine thousand dollars*
11 *(\$2,479,000) shall be administered and allocated through the*
12 *rural health services program, Chapter 4 (commencing with*
13 *Section 16930) of Part 4.7 of Division 9 of the Welfare and*
14 *Institutions Code.*

15 (c) *Funds allocated by this section from the Physician Services*
16 *Account and the Unallocated Account in the Cigarette and*
17 *Tobacco Products Surtax Fund shall be used only for the*
18 *reimbursement of uncompensated emergency services, as defined*
19 *in Section 16953 of the Welfare and Institutions Code. Funds shall*
20 *be transferred to the Physician Services Account in the county*
21 *Emergency Medical Services Fund established pursuant to*
22 *Sections 16951 and 16952 of the Welfare and Institutions Code.*

23 (d) *Funds allocated by this section from the Hospital Services*
24 *Account in the Cigarette and Tobacco Products Surtax Fund shall*
25 *be used only for reimbursement of uncompensated emergency*
26 *services, as defined in Section 16953 of the Welfare and*
27 *Institutions Code, provided in general acute care hospitals*
28 *providing basic, comprehensive, or standby emergency services.*
29 *Reimbursement for emergency services shall be consistent with*
30 *Section 16952 of the Welfare and Institutions Code.*

31 SEC. 77. (a) *The State Department of Health Services may*
32 *not implement limits on laboratory services provided by more than*
33 *one laboratory, as provided for in the Budget Act of 2003 until, at*
34 *a minimum, an Internet and telephone process are available for*
35 *applicable providers to access the laboratory service reservation*
36 *system.*

37 (b) *The Legislature finds and declares both of the following:*

38 (1) *The laboratory service reservation system will allow*
39 *laboratories, prior to performing a lab procedure, the opportunity*

1 to verify that service limits have not been reached for that
2 procedure and for that Medi-Cal beneficiary.

3 (2) It is the intent of the State Department of Health Services to
4 have the laboratory service reservation system accessible through
5 a point of service device process within 9 to 12 months after the
6 enactment of this act.

7 SEC. 78. The State Department of Health Services shall
8 require contractors and grantees under the Office of Family
9 Planning, Male Involvement Program, and Information and
10 Education Program, to establish and implement, commencing in
11 the 2003–04 fiscal year, a clinical services linkage to the Family
12 PACT program. This linkage shall include, but not be limited to,
13 planning and development of a referral process of participants in
14 these programs to ensure access of family planning and other
15 reproductive health care services. This clinical services linkage
16 shall commence in the 2003–04 state fiscal year and operate
17 thereafter.

18 SEC. 79. The State Department of Health Services may adopt
19 emergency regulations to implement the applicable provisions of
20 this act in accordance with the rulemaking provisions of the
21 Administrative Procedure Act (Chapter 3.5 (commencing with
22 Section 11340) of Part 1 of Division 3 of Title 2 of the Government
23 Code). The initial adoption of emergency regulations and one
24 readoption of the initial regulations shall be deemed to be an
25 emergency and necessary for the immediate preservation of the
26 public peace, health, or general welfare. Initial emergency
27 regulations and the first readoption of those regulations shall be
28 exempt from review by the Office of Administrative Law. The initial
29 emergency regulations and the first readoption of those
30 regulations authorized by this section shall be submitted to the
31 Office of Administrative Law for filing with the Secretary of State
32 and publication in the California Code of Regulations and each
33 shall remain in effect for no more than 180 days.

34 SEC. 80. The Managed Risk Medical Insurance Board may
35 adopt emergency regulations to implement provisions of this act
36 repealing Section 12698.10 of, adding Section 12693.765 to, and
37 amending Sections 12693.43, 12693.70, 12693.73, 12695.06,
38 12698.05, and 12698.30 of, the Insurance Code. The Office of
39 Administrative Law shall consider those regulations to be
40 necessary for the immediate preservation of the public peace,

1 health and safety, and general welfare for purposes of Section
2 11349.6 of the Government Code. Notwithstanding the 120-day
3 limitation in subdivision (e) of Section 11346.1 of the Government
4 Code, the emergency regulations adopted or amended pursuant to
5 this subdivision shall be repealed 180 days after the effective date
6 of the regulations, unless the department readopts those
7 regulations, in whole or in part, in compliance with Chapter 3.5
8 (commencing with Section 11340) of Part 1 of Division 3 of Title
9 2 of the Government Code.

10 SEC. 81. No reimbursement is required by this act pursuant
11 to Section 6 of Article XIII B of the California Constitution for
12 certain costs that may be incurred by a local agency or school
13 district because in that regard this act creates a new crime or
14 infraction, eliminates a crime or infraction, or changes the penalty
15 for a crime or infraction, within the meaning of Section 17556 of
16 the Government Code, or changes the definition of a crime within
17 the meaning of Section 6 of Article XIII B of the California
18 Constitution.

19 However, notwithstanding Section 17610 of the Government
20 Code, if the Commission on State Mandates determines that this
21 act contains other costs mandated by the state, reimbursement to
22 local agencies and school districts for those costs shall be made
23 pursuant to Part 7 (commencing with Section 17500) of Division
24 4 of Title 2 of the Government Code. If the statewide cost of the
25 claim for reimbursement does not exceed one million dollars
26 (\$1,000,000), reimbursement shall be made from the State
27 Mandates Claims Fund.

28 SEC. 82. This act is an urgency statute necessary for the
29 immediate preservation of the public peace, health, or safety
30 within the meaning of Article IV of the Constitution and shall go
31 into immediate effect. The facts constituting the necessity are:

32 In order to make the necessary statutory changes to implement
33 the Budget Act of 2003 at the earliest possible time, it is necessary
34 that this act take effect immediately.

1		_____
2	CORRECTIONS	
3	Heading — Line 1.	
4	Title — Line 1.	
5	Digest — Page 2.	
6	Text — Pages 3,4.	
7		_____
8		

